Crutchfield Dermatology

"Look Good, Feel Great with Beautiful Skin"

Charles E. Crutchfield III, M.D.
Diplomate, American Board of Dermatology
Fellow, American Academy of Dermatology
Clinical Associate Professor of Dermatology at the University of Minnesota
Mayo Clinic Medical School Graduate

General Dermatology
- Acne
- Psoriasis
- Skin Cancer
- Mole Checks
- Skin Exams
- Warts
- Rashes
- Pediatrics
- Skin Surgery
- Ethnic Skin
- Vitiligo

Laser Surgery
- Acne
- Birthmarks (Port Wine)
- Warts
- Unwanted Hair
- Facial Veins
- Sun Damaged Skin
- Age Spots
- Wrinkles
- Pixel Laser for Acne scars and fine lines

Phototherapy Center
- Psoriasis
- Vitiligo
- Atopic Dermatitis
- Eczema
- Pruritus

Cosmetic Dermatology
- Botox Cosmetic
- Restylane • Juvederm • Perlane
- Laser Treatments
- DermiSpa
- Skin Rejuvenation Programs
- Peels
- Javani Facials
- Microdermabrasion
- Wrinkle Treatments
- Lipodissolve Ultra
- Mesotherapy
- AFT Photo Facials

1185 Town Centre Drive
Suite 101
Eagan, Minnesota 55123

Appointments: 651.209.3600
Fax: 651.209.3601

www.CrutchfieldDermatology.com

Authorization for Release of Medical Information

Patient Information:

Name: _____ Date of Birth: ___/____/_____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: ( ) _____ - _____

Type of Information Requested:

☐ Office Visit Notes ☐ Pathology Reports
☐ Lab reports / Blood Tests
☐ Other _____

Information to be released from:

Physician & Clinic Name: Crutchfield Dermatology
Street Address: 1185 Town Centre Dr #101
City: Eagan State: MN Zip: 55125
Phone: (651) 209-3600 Fax: (651) 209-3601

Information to be received by:

Physician & Clinic Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: ( ) _____ - _____ Fax: ( ) _____ - _____

Information to be released for the following reason:

☐ Personal Record ☐ Transfer of Care ☐ Consult
☐ Copy for my Primary Care Doctor ☐ Insurance Claim
☐ Other _____

The following items must be checked (✓) **and initialed** if you would like these items included in the use and disclosure of other health information.
Again, please check and initial on the lines near the items you would like included:
____HIV/AIDS related information and/or records
____Mental Health information and/or records
____Genetic testing information and/or records
____Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.)
Describe:_____
_____

Patient Signature _____ Date _____

Witness _____ Date _____