FLORIDA DERMATOLOGY SPECIALISTS

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please complete all sections of this form and return to 772-403-2230 (fax)

Patient Name: _____ Date of Birth: _____

I hereby authorize Florida Dermatology Specialists to release medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing and treatment, AIDS related information, and genetic information as it concerns the above referenced patient as follows:

For the dates of service from: _____ to: _____

RELEASE TO:

_____
ENTITY OR PERSON NAME

_____
STREET ADDRESS CITY, STATE, ZIP

_____ _____
TELEPHONE FAX NUMBER

WHAT TO RELEASE:

☐ All Medical Records/Information ☐ Abstract ☐ Billing records ☐ Outpatient Record ☐ Diagnostic Test/Results
☐ History & Physical ☐ Discharge Summary ☐ Other: _____

PURPOSE (i.e., my medical care, legal purposes, etc.): _____

FORMAT: I request that my medical information be provided as follows:

☐ On paper ☐ In an electronic format ☐ Discuss my medical information only ☐ Other: _____
If requesting an unencrypted format, by signing below you acknowledge that you understand the inherent risks involved with sending and receiving information in an unencrypted, unsecured, format (such as regular email or unencrypted disc). Such risks include misdirected messages, email intrusion, interception, or views by unauthorized parties.

EXPIRATION:

This authorization will be valid for one year from the date signed, unless otherwise specified here: _____Expiration Date
This authorization is voluntary. Refusal to sign this authorization will not lead to an impact on my treatment, or refusal by my provider to provide treatment services to me. I understand that my provider may charge me a reasonable fee, as allowed by law, for a copy of my health information. I may revoke this authorization by submitting my request in writing to the clinic or department where I submitted this authorization but understand that such revocation will not apply to actions already taken by my health care provider prior to my revocation. I also understand that once my medical information is disclosed based on this authorization, it may be further used or disclosed and will no longer be protected by state or federal privacy laws.

Signed: _____ Date: _____
(patient or representative)

_____ Telephone Number:_____
(relationship to patient if not patient)

For individuals/representatives acting on behalf of the patient, you must indicate your relationship to the patient above, and attach proof of your authority to act on the patient's behalf (other than parents).