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FIRST COAST DERMATOLOGY
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL BY THE PATIENT

I, _____ hereby authorize Dr. _____

Patient's Name: _____ D.O.B _____

Address: _____ Phone #: _____

This authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, the authorization will expire in 1 year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations.

I understand that any disclose of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

$5.00 for the first 10 pages $15.00 more than 10 pages

If copies are to be sent to another provider the fee will be waived.

The information you may release subject to this signed form is as follow

__ Complete Records __ Labs __ Progress Notes

__ Therapy Records __ Pathology Reports __ Other: _____

__ Medical history __ Diagnostic Test Results

Release my health information to the following physician/person/facility/entity

Release to: _____ Phone Number: _____

Fax Number: _____ Address: _____

You must provide our office the fax number of the provider you want us to send copies of your records to. Failure to provide us with this number, we won't be able to send/request any medical information.

_____

SIGNATURE OR PATIENT/LEGAL REPRESENTATIVE DATE OF AUTHORIZATION

OFFICIAL USE ONLY

This form has been approved by: _____