Dermatology Associates
OF TALLAHASSEE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please Print Clearly

Name _____
(last) (first) (initial)

Address _____
(street) (city) (state)

Phone (____)_____Date of Birth _____ Medical Record # _____

I authorize _____ to release medical information from my medical record to:

Name of Doctor, Hospital, etc, _____

Address_____

City/State/Zip Code _____

Reason for request _____

For the purpose of review/ examination. I further authorize you to provide such copies thereof as may be requested. The forefoing is subject to such limitation as indicated below:

- ❑ Entire record
- ❑ Specific information_____
- ❑ Old records from previous physicians _____

I give special permission to release any information regarding: (initial on appicable line(s) below)

_____ Substance Abuse _____ Psychiatric/Mental Health Information _____ HIV Information

This authorization will automatically expire one year from the date sign. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date _____
(If not patient, state relationship)

Witness _____ Date _____

For Office Use Only

Received _____ Completed By _____

Completed _____ Fee Paid _____

Amount Billed _____ Amount Due _____

Disclosure Consisted Of _____

_____

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