DERMATOLOGY +
PLASTIC SURGERY
For Your Best Self

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A FOREFRONT PRACTICE

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Authorization for Use or Disclosure of Medical Record Information

Release Information To (check one):

- ☐ *I hereby authorize Dermatology + Plastic Surgery to release my medical record information to the physician/facility listed below.*
- ☐ *I hereby authorize the physician/facility listed below to release my medical information to Dermatology + Plastic Surgery.*

Name: ______________________________
Address: ______________________________
Phone: ____________________ Fax: ____________________

Delivery Preference (check one):

- ☐ Mail copies to address listed above
- ☐ Hold for patient pick-up
- ☐ Secure email: ____________________
- ☐ Fax: ____________________
- ☐ Discuss medical information with: (name) ____________________
- ☐ (phone) ____________________

Information To Be Released (check one):

- ☐ Progress notes only
- ☐ Laboratory notes only
- ☐ Pathology reports only
- ☐ All records
- ☐ Other (specify records needed): ____________________

Purpose for Need or Disclosure (check one):

- ☐ Continued patient care
- ☐ Insurance claim/application
- ☐ Attorney/legal
- ☐ Change of physician/relocation
- ☐ Other: ____________________

Per Florida Statute 455 the following fees apply if you are requesting paper copies of your medical records for personal use: $0.39 per page up to 25 pages and $0.25 per page thereafter, shipping charges if records are mailed will be the responsibility of the patient. There is no charge for records sent directly to other medical providers or facilities.

I understand that the information released is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold any employee of Florida Dermatology Plastic Surgery liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.

Patient Name: ______________________________ *Date of Birth:* ____________________
Address: ______________________________
____

____________________ ____________________ ____________________
Signature of Patient Relationship to Patient (self, parent, spouse) Date

For office use only. Staff initials: Date/time handled: ____________________ Means of transmittal: