Phone: 407-299-7333
Fax: 407-293-2049

MEDICAL RECORDS RELEASE FORM

I,_____ for_____

Date of Birth:_____ Social Security No._____

Give authorization for Mid Florida Dermatology Associates to: **CHECK ONLY ONE**

_____ Release my medical records to:

_____ Obtain my medical records from:

_____ Discuss my medical records with:

Name of person or facility receiving:_____

Address:_____

Phone No.:_____ For the purpose of:_____

THE SPACES BELOW GIVE SPECIAL AUTHORIZATION OR THE RELEASE OF INFORMATION REGARDING ALCOHOLISM AND/OR DRUG ABUSE, MENTAL HEALTH/REHABILITATION, HIV (AIDS) TESTING, AND/OR TESTING FOR SEXUALLY TRANSMITTED DISEASES.

INITIAL OR CHECK EACH LINE THAT APPLIES

_____ Medical information regarding alcoholism and/or drug abuse (if applicable) may be released to the recipient noted above.

_____ Medical information regarding mental health/rehabilitation (if application) may be released to the recipient noted above.

_____ Medical information regarding HIV (AIDS) testing and/or testing for sexually transmitted diseases (if applicable) may be released to the recipient noted above.

NOTE: Only a limited medical summary will be sent if all the above are not initialed or checked.

I understand this consent is revocable by me, in writing, at any time except after the action has taken place. I understand that this consent will expire either ninety days after the date of signature or automatically when the records requested on this form have been mailed to the above requested facility. I also understand that Mid Florida Dermatology Associates is authorized by Florida law to charge me for duplication costs incurred in connection with copying my medical records.

Date:_____ Patient Signature:_____

Guardian Signature:_____

Witness Signature:_____