

# Dermatology Consultants of South Florida, P.A.

## AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

[ ] 3000 University Drive, Ste. K      [ ] 7800 W. Oakland Park Blvd., Ste. 116      [ ] 1460 N. University Dr.  
Coral Springs, FL 33063                      Sunrise, FL 33351                      Coral Springs, FL. 33071  
Phone: (954) 752-2630 ext. 214              Phone: (954) 742-0306                      Phone: (954) 752-7552  
Fax: (954) 510-7274                              Fax: (954) 746-5231                              Fax: (954) 752-4737

[ ] Call patient to pick up records                      [ ] Mail to patient or other \_\_\_\_\_

\_\_\_\_\_  
NAME OF PATIENT                                      DATE OF BIRTH                                      ID NUMBER  
By signing this information, I authorize Dermatology Consultants to **use, receive or disclose** certain (PHI) protected Health information about me.

Records going to: \_\_\_\_\_                                      Records coming from: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone #: \_\_\_\_\_                                      Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_                                      Fax #: \_\_\_\_\_

Medical Records to be released/requested: [please mark the box(es)]  
[ ] Complete Medical Records      [ ] Doctor's Notes                      [ ] Other: \_\_\_\_\_  
[ ] Biopsy Report(s)                      [ ] Allergy Information  
[ ] Labs Report(s)                      [ ] Surgical Procedures

For Date of Service from: \_\_\_\_\_ to: \_\_\_\_\_

The information will be used for the following purpose (i.e. new doctor, review, moving, etc.):  
X \_\_\_\_\_

This form will expire one year from signed date.

The practices will \_\_\_\_\_ or will not \_\_\_\_\_ receive payment or other remuneration from a third party in exchange for **using, receiving, or disclosing the PHI.**

**I do not** have to sign this authorization form in order to receive treatment from Dermatology Consultants. In fact, I have the right to refuse to sign this authorization form. When my information is **used, received, or disclosed** pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: 3000 University Dr. Suite J, Coral Springs, FL. 33065. Attn: Dr. J. Kroll

Signed By: X \_\_\_\_\_                                      \_\_\_\_\_  
Signature of patient or legal guardian                                      Relationship to patient  
X \_\_\_\_\_                                      X \_\_\_\_\_  
Print name of patient or legal guardian                                      Date