Hollywood Dermatology & Cosmetic Specialists

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below; I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY RECORDS TO: _____

PLEASE SELECT ONE DELIVERY METHOD:

❒ **REGULAR MAIL:** _____ **OR** ❒**FAX:** _____

Mailing Address *Fax Number*

_____

City, State, and Zip

Please forward a copy of the following medical records:

_____ COMPLETE MEDICAL RECORDS _____ CONSULTATION REPORTS _____ MEDICATIONS/ALLERGIES

_____ BIOPSY REPORTS _____ LAB REPORTS _____ SURGICAL PROCEDURES

For the following dates of service: _____to _____

Today's Date: _____ Patient/ Guardian Signature: _____

IN ACCORDANCE TO STATUTE 64B8-10.003 COSTS OF REPRODUCING MEDICAL RECORDS:

I understand and agree that I am financially responsible for the following fees associated with my request of copying charges and production of my information. I understand that the charge for this service is as follows: For the first 25 pages, $1.00 per page after 25 pages a charge of 0.25 cents per additional page.

PLEASE FAX OR EMAIL YOUR REQUESTS TO:

Hollywood Dermatology Doral
3470 NW 82nd Ave Suite 111, Doral, FL 33122
Office: (786)272-2500 I Fax: (786)353-2562
Email: MRDORAL@HOLLYWOODDERMATOLOGY.COM