DANIA DERMATOLOGY

• STANLEY SKOPIT, DO, MSE, FAOCD, FAAD

Authorization for Release of Medical Records

Must be completed for all authorizations

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:

Person/organization receiving the information

Name: _____

Address: _____

Suite: _____

City/State/Zip: _____

Phone#: _____ **Fax:** _____ **Email:** _____

PLEASE FORWARD A COPY OF THE FOLLOWING MEDICAL RECORDS

___ Complete Medical Records ___ Biopsy Reports ___ Lab Reports

___ Surgical Procedures Report

For the following dates of service: _____

Signature of patient or Patient Representative: _____ Date: _____

Printed Name of Patient or Representative: _____

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