Dermatology Consultants of South Florida, P.A.

- 3000 University Drive, Ste. K Coral Springs, FL 33065
- 1460 N. University Dr. Coral Springs, FL 33071
- 2929 University Drive, Ste. 101 Coral Springs, FL 33065
- 7800 W. Oakland Park Blvd., Ste. 116 Sunrise, FL 33351

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Please send all records to 3000 University Drive, Ste. K Coral Springs, FL 33065
Attn: Medical Records Dept.
Phone: (954) 780-8222 • Fax: (954) 510-7274 • Email: records@dermatologyflorida.com

Office Use only:
_____
MEDICAL RECORDS #

_____ _____
NAME OF PATIENT DATE OF BIRTH

[ ] Call patient to pick up records [ ] Mail to patient [ ] Other_____

By signing this form, I authorize Dermatology Consultants of South Florida, P.A. to **use, receive, or disclose** my complete Protected Health Information (PHI).

I request my records go to the following Person / Organization (if records are going to Yourself, write "Self"):

Name: _____

Address/Email Address: _____

_____

Phone #: _____

Fax #: _____

I request that you get my records from the following Provider / Organization:

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

NOTE: Any medical information sent via **unsecured e-mail** is inherently not secure and could result information being accessed while in transit.

Medical Records to be released / requested: (Please check all that apply)

[ ] Doctor's Notes [ ] Surgical Procedures
[ ] Biopsy Report(s) [ ] Complete Medical Records
[ ] Labs Report(s) [ ] Other: _____

State your urgency: _____
_____

For Date of Service from: _____ to: _____

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 re-disclosure 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 N.University Dr. Suite J, Coral Springs, FL 33065

This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information. This form will expire one year from signed date.

Signed By: X_____ _____
Signature of patient or legal guardian Relationship to patient

X_____ X_____
Print name of patient or legal guardian Date