BREVARD MEDICAL DERMATOLOGY

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AUTHORIZATION FOR REQUEST/RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Brevard Medical Dermatology to REQUEST / OBTAIN / RELEASE my medical records, which include, but are not limited to the following, pursuant to this authorization:

☐ All Healthcare Information ☐ Pathology Reports ☐ Progress Notes
☐ Operative Reports ☐ Lab Results ☐ Other_____

FROM / TO:

Name: _____

Address: _____

Phone: _____ Fax: _____

FOR THE PURPOSE OF:

☐ Personal Records ☐ Continued Care/Dr. _____ ☐ Insurance Company ☐ Other

_____ *(Initial)* I understand that I have the right to revoke this authorization at any time, and that if I revoke this authorization, I must send a request to: Brevard Medical Dermatology, 7960 N Wickham Road, Suite 103, Melbourne, FL 32940. I understand the revocation will not apply to information that has already been released in reliance on this authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ *(Initial)* I understand that the protected health information may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also contain information about behavioral or mental health services and treatment for alcohol and drug use.

Patient Name: _____ Date of Birth: _____

Name of Legal Representative (if applicable): _____

Address: _____

Signature of Patient or Legal Representative: _____ Date: _____