



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:

- checkbox All Healthcare Information
checkbox Operative Reports
checkbox Pathology Reports
checkbox Lab Results
checkbox Progress Notes
checkbox Other

FROM / TO:

Name: _____

Address: _____

Phone: _____ Fax: _____

FOR THE PURPOSE OF:

- checkbox Personal Records
checkbox Continued Care/Dr.
checkbox Insurance Company
checkbox 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, 8057 Spyglass Hill Road, Suite 102, 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: _____

800 Century Medical Drive
Suite B
Titusville, FL 32796
321-567-7530
Fax 321-225-8931

8057 Spyglass Hill Road
Suite 102
Melbourne, FL 32940
321-428-4737
Fax 321-241-6457

695 Cone Park Court
Merritt Island, FL 32952
321-453-3360
Fax 321-806-3005