UNIQUE
Dermatology & Wellness Center
WHERE BEAUTY & HEALTH MEET

MEDICAL RECORDS RELEASE FORM

Patient Name:_____

(first) (MI) (Last)

Address:_____

Date of Birth:_____**Social Security #:**_____

I give Dr. Dyan Harvey-Dent of Unique Dermatology & Wellness Center

AUTHORIZATION TO : ☐ **RELEASE**

☐ **OBTAIN**

the following information from/for my medical record ☐ T To ☐ From

Name of Person/Facility:_____

Address:_____**City:**_____**State:**_____

Zipcode:_____**Phone #:** (____)_____**Fax#:**(____)_____

Please check all information to be released:

_____History & Physical _____Pathology Results _____Operative Reports

_____ Progress Notes _____Labe Results _____Other (please specify)_____

This authorization covers medical care from: _____to _____(Date)

The purpose for release of this information is:

_____Personal Use ____Insurance _____Medical Care _____Legal Purpose

_____Social Security/Disability _____Other (please specify)_____

Authorization to Fax Medical Records: ☐ Yes ☐ No

I understand that this authorization is valid until revoked. I may revoke this authorization in writing at any time except to the extent that the action has already been made before the receipt of revocation. Additionally, I understand that a fee for preparing and furnishing this information may be charged according to ruling set forth by the Florida State Board of Medical Examiners.

Patient (Print):_____

Patient(Signature):_____
Date:_____

Parent/Executor/Legal Representative(Signature):_____


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