PREMIER DERMATOLOGY, MD

Authorization to Release Medical Records (protected health information)

Patient Name:_____
Date of birth:_____ Last four of social security #: _____
Address:_____
Phone Number:_____

I hereby authorize and request the release of the following information:
_____ All medical records
_____ Medical record information for visit dates of _____ to_____.
_____ Biopsy Results only
_____ Blood work only
_____ Progress Notes
Other:_____

FROM:
Premier Dermatology, MD
20803 Biscayne Blvd. Suite 305
Aventura, FL 33180
Telephone: (305) 521-8971
Fax: (786) 565-9381

TO:
_____
_____
_____

If the health information that I have requested Premier Dermatology, MD to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I give authorization for these records to be released to the party or parties authorized above. I also release Premier Dermatology, MD, and its officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

Patient Name:_____

Patient Signature:_____ Date:_____