



Mid-Florida Dermatology Associates

Dermatology and Dermatological Surgery

ORLANDO
100 W. Gore St. #600
Orlando, FL 32806
407.299.7333

WATERFORD LAKES
829 Woodbury Rd. # 103
Orlando, FL 32828
407.299.7333

METROWEST
7652 Ashley Park Ct. #305
Orlando, FL 32836
407.299.7333

NEW SMYRNA BEACH
519 North Dixie Freeway
New Smyrna Beach, FL 32168
386.428.2223

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I _____
(Name of Patient/Guardian) (Name of Patient/Self)

Social Security No: _____ Date of Birth: _____/_____/_____

Give authorization for **Mid-Florida Dermatology Associates** to: **CHECK ONLY ONE!**

- Release my medical records to:
- Obtain my medical records from:
- Discuss my medical records with:

Name of Person or Facility authorized: _____

Address: _____

Phone Number: _____ Purpose: _____

THE SPACE BELOW GIVES SPECIAL AUTHORIZATION OR THE RELEASE OF INFORMATION REGARDING ALCOHOL AND/OR DRUG ABUSE, MENTAL HEALTH/REHABILITATION, HIV (AIDS) TESTING, AND/OR TESTING FOR SEXUALLY TRANSMITTED DISEASES.

INITIAL OR CHECK EACH LINE THAT APPLIES

- Medical information regarding alcoholism and/or drug abuse (if applicable) may be released to the recipients noted above.
- Medical information regarding mental health/rehabilitation (if applicable) may be released to the recipients noted above.
- Medical information regarding HIV (AIDS) testing and/or the testing for sexually transmitted diseases (if applicable) may be released to the recipients noted above.

NOTE: Only a limited medical summary will be sent if all of the above are not initialed or checked.

I fully understand this consent is revocable by me, in writing, at any time except after the action has taken place. I understand that this consent will expire either after ninety days after the date of signature or automatically when the records requested on this form have been to/from the above requested facility. I also understand that Mid-Florida Dermatology Associates is authorized by Florida Law to charge me for duplication costs incurred in connection with copying my medical records.

Date: _____ SIGNATURE: _____
(Signature of Patient or Person authorized to give consent for the P atient)

Date: _____ WITNESS: _____
(Signature of Patient or Person authorized to give consent for the P atient)