Premier Dermatology of Florida
109 Whitehall Drive, Unit 117 | Saint Augustine, FL 32086
T: 904-460-2388 | F: 904-460-2689

Patient name (print): _____ Date: ____/ ____/ _____
Address: _____ Birth date: ____/ ____/ _____
_____ Phone (_____)_____

I authorize Premier Dermatology of Florida to:

_____ Send copies of your record to (discuss information with) the physician/person/facility below

OR

_____ Receive copies of your record from (or discuss your information with) the physician/person/facility below.

Name of Physician/Person/Facility: _____
Address: _____
City/State/Zip: _____
Phone (_____)_____ Fax: Phone (_____)_____

Information to be disclosed:

_____ Progress Notes
_____ Pathology/Lab Reports
_____ Operative Notes
_____ Cosmetic Notes
_____ Entire Medical Record

Restrictions: *Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request* to *Premier Dermatology of Florida.*

Patient gives consent to download information from pharmacies and other external sources as needed for medical care.

I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative signature: _____ Date: ____/ ____/ _____

Parent/Guardian signature required for minor (less than 18 years of age)

Relationship to patient (if other than self): _____

Printed name of authorized representative: _____ _