SOUTHEASTERN DERMATOLOGY GROUP, P.A.

Dermatology Specialists of AL|Dermatology Specialists of FL| Dermatology Specialists of GA|Dermatology Specialists of MS
PHONE: 877-231-DERM (3376) - FAX: 850-522-8354 – EMAIL: medicalrecords@dermsolutionsgroup.com

MEDICAL RELEASE CONSENT **(Complete all sections to prevent delays. Allow up to 14 business days for request to be processed.)**

Patient Legal Name:	Birth Date:	Social Security No. xxx-xx-____________

Patient Address ______________________________ Telephone No. ______________

City ______________________ State ________ Zip Code ______________

For Disclosure Only

I hereby authorize ____
Name of Physician and/or Practice Name to Release Records

____
Address

Fax Number ______________________ Telephone Number ______________________

To disclose medical record information and/or protected health information of the patient listed above to:

Name of Physician and/or Practice Name/Individual/Organization to Receive Records ______________________ Telephone Number ______________________

Address ______________________ Fax ______________________

Purpose: ____

Type of Access Requested :

- ☐ Copies of the record
- ☐ Inspection of the record
- ☐ Entire Record

Select Portions of Personal Health Information :

- ☐ Emergency Room
- ☐ History & Physical
- ☐ Consult Report
- ☐ Operative Report
- ☐ Lab
- ☐ Imaging / Radiology
- ☐ Demographics
- ☐ Progress Notes
- ☐ Medication Record
- ☐ Path Report
- ☐ Physician Orders
- ☐ Billing Records
- ☐ Other______________________

Expiration: This authorization shall expire in one year unless otherwise specified below:

- ☐ Fulfillment of this request (according to HIPAA or State Regulations, whichever is shorter)
- ☐ Date ________________________ (Not to exceed one year)

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. Fees/changes will comply with all laws and regulations applicable to release of information. Power of Attorney (POA) must be attached if signing as POA.

I have read the above and authorize the disclosure of the protected health information as stated.

Date	Signature of Patient/Responsible Party	Relationship to Patient

____
Address and telephone number of Requestor (if different from patient information)

Business Office Address: 215 Harrison Avenue- Panama City- FL- 32401