Sunshine State DERMATOLOGY AND SKIN CANCER CENTER

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Sunshine State Dermatology and Skin Cancer Center, Inc

By signing this authorization, I authorize (physician, person, office, etc.) _____

_____

to use and/or disclose certain protected health information (PHI) about me to or for **Sunshine State Dermatology and Skin Cancer Center, Inc**

This authorization permits _____ Fax: _____

to use or disclose to:

Sunshine State Dermatology and Skin Cancer Center Inc

12497 Tamiami Trail S, Unit 1

North Port, Florida 34287

Phone: 941-282-3376 / Fax: 941-282-3378

Records Requested

- o Specific date range (From: _____ To: _____)
- o Pathology/Laboratory reports only
- o Surgical reports only
- o All records
- o Other (specify): _____

I understand and agree that I am financially responsible for the following fees associated with my request to copy my records: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $1.00 per page for the first 25 pages and $0.25 for each page in excess of 25 pages, with a minimum charge of $10.

This authorization expires on: _____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

Printed Patient's Name: _____ Date of Birth: _____

Signature of Patient or Legal Guardian: _____ Date: _____

Relationship to patient: _____