DERMATOLOGY
ASSOCIATES OF TAMPA BAY

Hair & Vein Removal • Sun Spot Removal• Collagen• Skin Tightening • Botox • Skin Care • Chemical Peels

REQUEST FOR RELEASE OF MEDICAL RECORDS

I HEARBY REQUEST AND AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM:

PHYSICIAN: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

FAX NUMBER: _____

PATIENT SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ DATE OF BIRTH: _____

WITNESS: _____ DATE: _____

TO BE SENT OR FAXED TO:

PHYSICIAN: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

FAX NUMBER: _____

PLEASE SEND THE FOLLOWING INFORMATION: ____Complete Record _____Biopsy/Labs
_____Surgical Procedures _____Other _____

FOR DATES OF SERVICE: _____

*****In accordance with Florida Law we require *specific separate authorization* to release superconfidential information. If you agree to the release this information, please initial the appropriate categories listed below and sign at the bottom.**

_____HIV/AIDS Information
_____Mental Health Information
_____ Substance Abuse Information
_____Sexually Transmitted Disease, Hepatitis or Communicable Disease Information
_____ If the patient is under the age of (18), Pregnancy information.

_____ _____

Patient Signature Date