Varee N. Poochareon, MD • Franz R. Kerdel, DO, FAAD • Caitlin M. Lutz, MCMSc, PA-C
Sholomo J. Lanes, MD, ABVLM, FACP • Frank Don, DO

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below; I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: ________________________________ Date of Birth: ____________________

Address: ______________________________________ Phone: ________________________

I AUTHORIZE Skin Center of South Miami to disclose the following protected health information about me to:

____

Name of physician, practice, facility, or person(s) where records will be sent.

Please forward a copy of the following medical records:

❒ COMPLETE MEDICAL RECORDS ❒CONSULTATION REPORTS ❒MEDICATIONS/ALLERGIES

❒ BIOPSY REPORTS ❒LAB REPORTS ❒SURGICAL PROCEDURES

***For the following dates of service:* __________________ *to* _____________**

SELECT ONE DELIVERY METHOD

❒ **MAIL**

____

Mailing address

____

City/ State/ Zip

❒ **FAX**

____

Fax Number

________________________________ _________________________ ________________

Patient/Parent/Legal Guardian Signature ***Relationship*** ***Date***

This Permission Expires on ____________________

Expiration Date

Skin Center of South Miami
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Office: (305)740-6181 Fax: (305)740-6181