

# Dermatology Consultants of South Florida, P.A.

- 3000 University Drive, Ste. K Coral Springs, FL 33065
- 1460 N. University Dr. Coral Springs, FL 33071
- 2929 University Drive, Ste. 101 Coral Springs, FL 33065
- 7800 W. Oakland Park Blvd., Ste. 116 Sunrise, FL 33351

## AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Please send all records to 3000 University Drive, Ste. K Coral Springs, FL 33065

Attn: Medical Records Dept.

Phone: (954) 780-8221 • Fax: (954) 376-7929 • Email: [tphan@dermatology.fdn.com](mailto:tphan@dermatology.fdn.com)

Office Use only:

MEDICAL RECORDS #

NAME OF PATIENT

DATE OF BIRTH

Call patient to pick up records     Mail to patient     Other \_\_\_\_\_

By signing this form, I authorize Dermatology Consultants of South Florida, P.A. to use, receive, or disclose my complete Protected Health Information (PHI).

I request my records go to the following Person / Organization (if records are going to yourself, write "Self"):

Name: \_\_\_\_\_

Address/Email Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

I request that you get my records from the following Provider / Organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

**NOTE:** Any medical information sent via **unsecured e-mail** is inherently not secure and could result information being accessed while in transit.

**Medical Records to be released / requested:** (Please check all that apply)

- Doctor's Notes                       Surgical Procedures  
 Biopsy Report(s)                       Complete Medical Records  
 Labs Report(s)                           Other: \_\_\_\_\_

State your urgency: \_\_\_\_\_

For Date of Service from: \_\_\_\_\_ to: \_\_\_\_\_

I do not have to sign this authorization form in order to receive treatment from Dermatology Consultants. In fact, I have the right to refuse to sign this authorization form. When my information is **used, received, or disclosed** pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: 3000 University Dr. Suite J, Coral Springs, FL 33065 Attn: Mari.

This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information. This form will expire one year from signed date.

Signed By: X \_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Relationship to patient

X \_\_\_\_\_  
Print name of patient or legal guardian

X \_\_\_\_\_  
Date