VENICE AVENUE DERMATOLOGY

MEDICAL RECORDS - RELEASE or ACQUISITION

PATIENT NAME: _____ DOB: _____

*__PLEASE NOTE__: WITHOUT YOUR WRITTEN CONSENT, WE CANNOT RELEASE OR OBTAIN RECORDS FROM OTHER PROVIDERS.

I authorize **VENICE AVENUE DERMATOLOGY** to: **OBTAIN** or **RELEASE** MY MEDICAL RECORDS
FROM (NAME OF PRACTICE, FACILITY OR PROVIDER):_____
FAX NUMBER: _____

TYPE OF INFORMATION TO BE RELEASED OR OBTAINED:

- ☐ BILLING STATEMENTS
- ☐ OPERATIVE REPORTS
- ☐ LABORATORY REPORTS
- ☐ PROGRESS NOTES
- ☐ PATHOLOGY REPORTS
- ☐ OTHER _____

SPECIFY DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE: _____

THE PURPOSE OF THIS RELEASE IS:

- ☐ AT THE REQUEST OF THE PATIENT/PATIENT REPRESENTATIVE
- ☐ OTHER (PLEASE STATE REASON) _____

NOTICE:

We are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS:

- ☐ I understand this authorization is voluntary.
- ☐ I may revoke this authorization at any time, provided I do so in writing and submit it to **VENICE AVENUE DERMATOLOGY, 897 E. VENICE AVE. STE. A, VENICE, FL 34285**
- ☐ The revocation will take effect when we receive it.
- ☐ I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this Authorization expires on:_____ (insert applicable date or event).
If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

SIGNATURE _____ DATE: _____
PATIENT OR LEGAL GUARDIAN

NAME OF GUARDIAN: _____ RELATIONSHIP:_____

PHONE NUMBER: _____ WITNESS: _____