MEDICAL RECORDS RELEASE FORM

Patient Last Name: _____ First Name: _____
Date of Birth: _____
Address: _____
Phone: _____

I, the undersigned, hereby authorize Dermatology Associates of the Palm Beaches, PLLC, located at 1551 Forum Place, Suite 100A, West Palm Beach, FL 33401 ("Dermatology Associates"), to provide my medical record to:

_____

I understand that the records you release may contain information pertaining the following:

Consultations/examinations Mental health information Results of diagnostic testing

Diagnosis of sexually transmitted diseases Drug and alcohol abuse information.

I understand that if I do not want any of the above information released, I may limit your authorization to release such information by crossing it out and initialing it. If there is other information that I specifically do not want released, I should identify it in the following space:
_____ (if none, write "none")

Right to Revoke Authorization: I understand that I may revoke this authorization at any time by notifying you in writing at the address set forth on this page. I understand that if you have already released information or otherwise acted in reliance upon this authorization, that any subsequent revocation will not affect the validity of you prior disclosure or other action. I also understand that if this authorization was provided for purpose of obtaining insurance coverage, my revocation might give rise to the insurer's right to contest a claim and/or to contest the validity of any insurance issued in reliance of the authorization.

Termination: If not revoked by me sooner, this authorization will terminate six months from the date of signature.

Right to inspect Information: I understand that I have the right to inspect the information to be disclosed.

- A photocopy or other electronic copy of this authorization will be treated as an original.
- Dermatology Associates may have received health records from other providers which have been incorporated into your records at Dermatology Associates. If those records are included in those authorized above, they will be released pursuant to this authorization.
- Dermatology Associates cannot prevent re-disclosure of your information by the person or organization that receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Dermatology Associates from any and all liability resulting from a disclosure by the recipient.
- Your signature below indicates you have read and understand this form and authorize release of the information as described above.

_____ _____ _____
Name Signature Date