Abrams Dermatology

Bradley J. Abrams, D. O.
A.O.B.D. Board Certified Dermatologist
Fellow American Society of MOHS Surgery
Sheryl Wilson, ARNP-C

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

RELEASE FROM:

Patient Information

_____ DOB: _____
First Middle Last Name

_____
Mailing Address

_____
City State Zip

_____
Daytime phone number Evening phone number

FORWARD TO:

I hereby authorize to use or disclose my PHI as indicated below to :

_____
First Middle Last Name

_____
Mailing Address

_____
City State Zip

_____
Phone number Fax number

INFORMATION TO BE RELEASED:

For dates of service from _____ to _____

- □ Complete Medical Record
- □ Biopsy Report(s)
- □ Lab Report(s)
- □ Consultation Report(s)
- □ Surgical Procedures
- □ Other _____

PURPOSE OF DISCLOSURE:

- □ Changing physicians
- □ Continuing Care
- □ At my (patient) request
- □ Second Opinion
- □ Insurance
- □ Legal
- □ Other _____

RELEASE TYPE:

Check one: □Paper □Electronic □CD □USB fob
Check one: □Pick up □Mail □Fax Number _____ □Email Address _____

If you are leaving us due to a bad experience, please let us know so we can improve:

_____

_____

This authorization will expire two years from the request date. | A photocopy of this form will be considered as valid as the original. | You may revoke this authorization at any time by notifying us at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. | Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations | Your health care and payment for your health care will not be affected if you do not sign this form. | You will receive a copy of this form after you sign it.
You may be charged a reasonable medical records copying fee as permissible by Florida State Law. By law, we are only permitted to release your medical records to you (the patient). By listing the individual above (FORWARD TO), you have given us permission to release your medical records to this person. We may require a photo ID to be sent by fax or email to us along with the form to match signatures. We cannot disclose any of your private health information to anyone who is not listed on this form.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____
Request Date Patient Signature Parent/Legal Guardian/Authorized Person Signature Relationship to patient

_____ _____
Records Received By Date

For Office Use Only

Date Request Filled _____ By _____ Fee Collected $ _____ Identification Verified: _____
Type

Original Date of Form: Effective Date: July 12, 2013