Precision Dermatology and Skin Surgery, P.A.
Board Certified in Dermatology
Fellowship Trained in Dermatologic Surgery

Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Last 4 of Social Security #: _____ Phone Number: _____

I authorize Precision Dermatology and Skin Surgery, P.A. to disclose my protected health information to the physician, facility, or person listed below:

Name/Facility: _____

Address: _____

_____

Phone Number: _____ Fax: _____

Information to Be Released: _____

_____

Purpose Needed for Disclosure: _____

_____

I understand that the information released is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold any employee of Precision Dermatology and Skin Surgery, P.A. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

I understand any records exceeding fifteen pages will be sent to me via USB flash drive unless otherwise specified above.

Patient Signature: _____ Date: _____

Please be as detailed as possible when completing release.
Incomplete request may cause a delay when processing.
Processing of medical records normally takes 1-2 weeks but can take up to 30 days.