Central Florida DERMATOLOGY ASSOCIATES

ID #:

Medical and/or Financial Records Release Authorization Form

For your protection and privacy, it is our policy not to release any information regarding your medical and/or financial history to anyone without your authorization. This consent does not authorize our office to release HIV/AIDS status and/or drug and/or alcohol dependency. It is your responsibility to notify us of any changes that need to be made to this form. This authorization remains in effect unless changed or revoked in writing.

Please Transfer the ☐ Medical ☐ Financial Records of:

PATIENT NAME _____ **DOB** _____

From: _____ **To:** _____

Name* **Name***

Street Address **Street Address***

City, State Zip **City, State Zip***

Phone* **Phone*** **Fax***

***Required Information**

A **Medical Records Payment Form** is required to be completed **prior** to medical records processing. Please allow 48 business hours for processing.

Records requested to be (choose ONE of the following):

☐ Picked up in person at Central Florida Dermatology (M-Th 7am-12pm, 1pm-5pm)
- I understand that I will be charged $1.00 per page, up to 25 pages, and $0.25 each page thereafter. I have completed a medical records payment form for this purpose.

☐ Mailed to Address above
- I understand that I will be charged $1.00 per page, up to 25 pages, and $0.25 each page thereafter. I have completed a medical records payment form for this purpose.
- I understand the above fees will be waived if the recipient is a medical doctor's office or health insurance company.

☐ Faxed to a Medical Office – No fee

I authorize Kathleen W. Judge, M.D., F.A.A.D and/or Central Florida Dermatology Associates, P.A. to release my medical/financial records when requested to the above listed family member, third party organization and/or physician.

_____ _____
Patient/Guardian Signature Date

_____ _____
Central Florida Dermatology Representative Date