Central Florida DERMATOLOGY ASSOCIATES

ID #:

Medical and/or Financial Records Payment 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.

PATIENT NAME _____ **DOB** _____ **SSN** _____

Paper Records: $1.00 per page, up to 25 pages, and .25 cents each page thereafter.
Records on Flash Drive: $5.00

Records will be released in the method indicated on your Medical Release Form 48 business hours after receipt of payment.

I authorize Kathleen W. Judge, M.D., F.A.A.D. and/or Central Florida Dermatology Associates, P.A. to collect payment for my medical/financial records as requested in writing.

Indicate Method of Payment:

☐ Personal Check…….Check #:_____

☐ Cash

☐ Credit Card……..Type of CC: ☐ VISA ☐ Mastercard ☐ Discover

Name on Card:_____

CC#:_____

Exp Date:_____

$_____Total Amount of Payment

_____ _____
Patient/Guardian Signature Date

_____ _____
Central Florida Dermatology Representative Date

CC: Medical Records Director