Dr. Deborah Longwill
Advanced Cosmetics and Dermatology

MIAMI CENTER FOR DERMATOLOGY

AUTHORIZATION FOR USE OF DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient Information:

Patient Name: _____ DOB: _____

Address _____ Phone: _____

City _____ State _____ Zip _____

Release Information To (check one):

☐ *I hereby authorize **Dr. Deborah Longwill** to release my medical record information to the physician or facility listed below.*

☐ *I hereby authorize the physician or facility listed below to release my medical information to **Dr. Deborah Longwill.***

☐ *I hearby request and authorize **Dr. Deborah Longwill** to release my medical records to myself and/or family member listed below*

Name/Facility: _____ Attention: _____

Address _____ Phone: _____

City _____ State _____ Zip _____ Fax: _____

Delivery Preference (check one):

☐ Mail copies to address listed above

☐ Hold for patient pick-up

☐ Fax: _____

Phone: _____

Information To be Released (check one):

☐ Progress notes only

☐ Pathology reports only

☐ Laboratory notes only

☐ All records

☐ Other (specify records needed): _____

Purpose for Need or Disclosure (check one):

☐ Continued patient care

☐ Attorney/legal

☐ Insurance claim/application

☐ Change of physical/relocation

☐ Other: _____

I understand that the information release 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 Dr. Deborah Longwill for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.

_____ _____ _____

Patient Signature | Relationship to Patient (self, parent, spouse) | Date

Please fax completed form or mail to address below, attention Medical Records.

For office use only. Staff Initial: _____ Date/time handled: _____ Means of transmittal: _____

7700 SW 104TH St. Pinecrest, FL 33156
Ph. 305.279.SKIN (7546) • www.longwillderm.com