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 or print in person (charges apply)
☐ Send via Patient Portal (Free of Charge)
☐ Fax ______________

Fax only available to healthcare offices or facilities

Information To be Released (check one):

☐ Progress notes only
☐ Pathology reports only
☐ Other (specify records needed): ______________________
☐ Laboratory notes only
☐ All records

Purpose for Need or Disclosure (check one):

☐ Continued patient care
☐ Attorney/legal
☐ Other: ______________________
☐ Insurance claim/application
☐ Change of physical/relocation

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: __________

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