AUTHORIZATION FOR THE RELEASE OF INFORMATION

I _____ _____
(Name of Patient/Guardian) (Name of Patient/Self)

Social Security No: _____ Date of Birth: _____/_____/_____

Give authorization for *Nola Dermatology to* **CHECK ONLY ONE!**

- ☐ Release my medical records to:
- ☐ Obtain my medical records from:
- ☐ Discuss my medical records with:

Name of Person or Facility authorized: _____

Address: _____

Phone Number: _____ Purpose: _____

THE SPACE BELOW GIVES SPECIAL AUTHORIZATION OR THE RELEASE OF INFORMATION REGARDING ALCOHOL AND/OR DRUG ABUSE, MENTAL HEALTH/REHABILITATION, HIV (AIDS) TESTING, AND/OR TESTING FOR SEXUALLY TRANSMITTED DISEASES.

INITIAL OR CHECK EACH LINE THAT APPLIES

- ☐ Medical information regarding alcoholism and/or drug abuse (if appliable) may be released to the recipients noted above.
- ☐ Medical information regarding mental health/rehabilitation (if appliable) may be released to the recipients noted above.
- ☐ Medical information regarding HIV (AIDS) testing and/or the testing for sexually transmitted diseases (if appliable) may be released to the recipients noted above.

NOTE: Only a limited medical summary will be sent if all of the above are not initialed or checked.

I fully understand this consent is revocable by me, in writing, at any time except after the action has taken place. I understand that this consent will expire either after ninety days after the date of signature or automatically when the records requested on this form have been to/from the above requested facility. I also understand that Mid-Florida Dermatology Associates is authorized by Florida Law to charge me for duplication costs incurred in connection with copying my medical records.

Date: _____ SIGNATURE: _____
(Signature of Patient or Person authorized to give consent for the P atient)

Date: _____ WITNESS: _____
(Signature of Patient or Person authorized to give consent for the P atient)