TREASURE COAST DERMATOLOGY

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

RECORDS RELEASE

RELEASE MEDICAL RECORDS TO / FROM (Please Circle):

Treasure Coast Dermatology:

□ 140 SW Chamber Ct, # 200, Port St Lucie, FL 34986
Ph: 772-878-3376 Fax: 772-879-9970

□ 448 SE Osceola St, Stuart, FL 34994
Ph: 772-221-3330 Fax: 772-221-3336

□ 2402 Frist Blvd, # 101, Fort Pierce, FL 34950
Ph: 772-464-6464 Fax: 772-464-6062

□ 1260 37th St, # 101, Vero Beach, FL 32960
Ph: 772-226-7218 Fax: 772-226-7534

□ 801 Wellness Way, # 103, Sebastian, FL 32958
Ph: 772-388-1740 Fax: 772-388-8623

RELEASE MEDICAL RECORDS TO / FROM (Please Circle):

____
Name

____
Street Address

____
City, State, Zip Code

____
Phone Number

____
Fax Number

PATIENT INFORMATION

Patient Name	Date of Birth	Phone Number	
Address	City	State	Zip
Patient Legal Guardian/Rep (If Applicable)	Relationship to Patient		

INFORMATION REQUESTED

Date(s) of Service: _________________________________

□ Pathology Reports □ Lab Results □ Other: (Specify): ____

PURPOSE

□ Self □ Continuing Medical Care □ Attorney Request □ Other: (Specify): ______________________________

This authorization will expire on the following: DATE: ____________________ OR EVENT: ________________________

DISCLOSURE OF SPECIALLY PROTECTED INFORMATION

My records may contain the following and, unless crossed out and initialed, I specifically authorize their release:

HIV Test Results (Test for AIDS)	AIDS Related Records	Drug or Alcohol Records	TB Records
STD Records (Sexually Transmitted Disease)	Mental Health Records	Pregnancy Records	

- I do not have to sign this authorization form in order to receive treatment from Treasure Coast Dermatology. In fact, I have the right to refuse to sign this authorization form.
- I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. My written revocation must be submitted to Treasure Coast Dermatology, Attn: Privacy Office, 140 SW Chamber Ct, #200, Port St Lucie, FL 34986
- I understand that if this information is disclosed to a third party, the information may no longer be protected by the state and federal regulations and may be re-disclosed by the person or organization that receives the information.

____ ____________________
Signature of Patient Date

______________________________________ _______________________ ____________________
Signature of Legal Guardian / Representative Relationship to Patient Date