Dermatology Solutions
14071 Metropolis Avenue, Fort Myers, FL 33912
Phone: (239) 694-7546 Fax: (239) 694-1571

Medical Records Release Form

Patient Name:_____ Date of Birth:_____

Patient Phone Number:_____

I authorize _____ to release medical information to:

Facility/Individual Name:_____

Fax/Email:_____

Phone:_____

Records to Include:

Pathology Report(s) _____ Clinical Records(s) _____ Laboratory test(s) _____

Complete Medical Records _____ Other:_____

Records may include HIV testing, mental health and/or substance abuse services.

Reason for Medical Records Request: _____

_____

This authorization applies to records related to HIV/AIDS, mental health, genetic testing, or drug/alcohol diagnosis. I understand that this release is only valid 30 days. I also understand that once released, my protected health information may be subject to redisclosure. I further release Dermatology Solutions and providers from all legal responsibility and/or liability that may arise from the release of such records. I have read the above and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature: _____ Date:_____