GRECO
DERMATOLOGY

MEDICAL RECORDS- RELEASE OR ACQUISITION

Without your written consent, we are not able to release or obtain records from other providers.

I authorize Greco Dermatology to: O Obtain My Records O Release My Medical Records

Name of practice, facility, or provider: _____

Patient Name: _____DOB: _____- _____- _____

Fax Number: _____

Type of information to be released or obtained:

O Billing Statements O Pathology Reports

O Progress Notes O Laboratory Reports

O Operativ Reports O Other: _____

Specify the date or time period for information selected above: _____

The purpose of this release is:

O At the request of the patient/patient representative

O Other (state reason) _____

NOTICE:

We are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS:

- I understand this authorization is voluntary.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to Greco Dermatology, 1990 Main Street, Suite 700, Sarasota, FL 34236. The revocation will take effect when we receive it.
- I am entitled to receive a copy of this Authorization

Expiration of Authorization:

Unless otherwise revoked, this Authorization expires (_____). If no date is indicated, this Authorization will expire in 12 months after the date of signing this form.

Signature: _____Date: _____- _____- _____

(Signature of Patient or Legal Guardian)

Name of Guardian: _____ Relationship: _____

Phone Number: _____Witness: _____