675 S Babcock St
Melbourne, FL 32901
P: 321-951-1010
F: 321-956-8471

AUTHORIZATION TO RELEASE/ OBTAIN MEDICAL RECORDS

Patient Name(PRINT):_____

Address:_____

Phone:_____ Date of Birth:_____

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I HEREBY AUTHORIZE INDIGO DERMATOLOGY TO : (release to) or (obtain from)
Please Circle One

Name:_____

Address:_____

Phone/Fax Number:_____

Any information, including diagnostic and medical records of any treatment or examination rendered to me during the information period:

☐ the past twelve (12) months

☐ from the time period of _____ to _____

And to include any federal and state protected under Florida statute 3 94.459(9) Psychiatric information, Florida Statute 397.501 and Florida Statute 397.112 Drug and /or Alcohol Abuse information and Florida Statute 381.004 and FAC 10D-39.064 Human Immunodeficiency Virus test results (HIV testing, AIDS and related conditions).

- I understand and direct that this authorization remain in effect until I revoke the authorization in writing to the Privacy Officer at the address above
- I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA
- I hereby release Indigo Dermatology and its employees from any and all liability that may arise from the release of this information as I have directed.

Signature:_____ Date:_____
(Patent, parent if minor, or legal guardian)

Relationship to Patient if signed by personal representative:_____

Witness:_____ Date:_____

☐ Please check her if records will be picked up. THERE IS A CHARGE FOR COPYING FOR PERSONAL PICK UP. This traditionally accepted fee is $1.00 per page for the first 25 pages, then $0.25 for every page after.

☐ Please check here if records are to be mailed.

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FOR OFFICE STAFF ONLY: ☐ Sent certified/ return receipt. Date mailed:_____

Article #:_____