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**Authorization for Release of Medical Information**

Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_(\_\_\_\_)\_\_\_\_\_\_\_\_\_

I authorize Oasis Dermatology, PLLC to:

\_\_\_ Send copies of your record to (or discuss information with) the provider/person/facility below

**OR**

\_\_\_ Receive copies of your record from (or discuss your information with) the provider/person/facility below.

Provider/Person/Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be disclosed:

\_\_\_\_\_Progress Notes

\_\_\_\_\_Pathology/Lab Report(s)

\_\_\_\_\_Operative Notes

\_\_\_\_\_Cosmetic Notes

\_\_\_\_\_Entire Medical Record

*Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.*

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I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Parent/Guardian signature required for minor (less than 18 years of age)

Relationship to patient (if other than self): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_