



Medical and/or Financial Records Release Authorization Form

PATIENT NAME

DOB

SSN

For your protection and privacy, it is our policy not to release any information regarding your medical and/or financial history to anyone without your authorization. If there are any family members, third party organizations or physicians to whom you would like to authorize us to release your medical and/or financial history, please list them below and indicate what type of information you are authorizing us to share with them when needed or requested. This consent does not authorize our office to release HIV/AIDS status and/or drug and/or alcohol dependency. It is your responsibility to notify us of any changes that need to be made to this form. This authorization remains in effect unless changed or revoked in writing. If records should only be released to your self/patient please note below.

Name and Phone Number

Information to Release

___ Medical ___ Financial

___ Medical ___ Financial

___ Medical ___ Financial

___ Medical ___ Financial

I understand that I will be charged \$1.00 per page, up to 25 pages, and .25 cents each page thereafter.

I am to submit payment in order to receive records upon receipt of payment.

I will receive my records by mail or in person.

There will be a 48 business hours turn around for records.

I authorize Kathleen W. Judge, M.D., F.A.A.D and/or Central Florida Dermatology Associates, P.A. to release my medical/financial records when requested to the above listed family members, third party organizations and/or physicians.

PATIENT/ GUARDIAN SIGNATURE

DATE

CFDA REPRESENTATIVE

DATE

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