Kathleen W. Judge, M.D., F.A.A.D
Central Florida Dermatology Associates, P.A.
700 E. Michigan St.
Orlando FL 32806
407-481-2620
407-992-7700 Fax

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 hour 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**