ID #:

Flash Drive Medical and/or Financial Records Release Authorization Form

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. 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.

Please Transfer the ☐ Medical ☐ Financial Records of:

PATIENT NAME ______________________ **DOB** ____________

From: Central Florida Dermatology
Name*

700 East Michigan Street
Street Address

Orlando, Florida 32806
City, State Zip

407-481-2620
Phone*

To: ______________________
Name*

____
Street Address*

____
City, State Zip*

____
Phone*

***Required Information**

There is a $5 charge for your medical records to be placed on a flash drive, this will include processing and a USB drive for you to keep. A **Medical Records Payment Form** is required to be completed **prior** to medical records processing. Please allow 48 business hours for processing. Records may be picked up in person at Central Florida Dermatology (M-Th 7am-12pm, 1pm-5pm).

I understand that I am choosing to receive my medical records on a device that is not encrypted.

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 to the above listed in a flash drive format.

______________________ ____________
Patient/Guardian Signature Date

______________________ ____________
Central Florida Dermatology Representative Date