Hollywood
Dermatology
& Cosmetic Specialists

Authorization for Release of Medical Records

Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually identifiable health information as described below; I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name:_____

Date of Birth:_____

I hereby authorize and request you to release my records to:

Person/Organization Receiving the information

Name:_____

Address:_____

Suite:_____

City/State/Zip:_____

Phone:_____Fax:_____

PLEASE FORWARD A COPY OF THE FOLLOWING MEDICAL RECORDS:

___Complete Medical Records ___Biopsy Reports ___Lab Reports

___Surgical Procedures/Reports

For the Following dates of service:_____

Signature of patient or Patient Representative: _____Date:_____

Printed Name of patient or Representative: _____

Office Locations:

Hollywood *3850 Hollywood Blvd* **Please email or fax to-**

mrhwd@dermcaremgt.com fax (954) 963-0378

Hallandale *1250 E Hallandale Beach Blvd Suite 800* **Please email or fax to-**
hallandalefrontdesk@dermcaremgt.com fax (954) 456-5095

Pembroke Pines *9050 Pines Blvd Suite 200* **Please Fax to (954) 433-8771**

Miramar *3000 SW 148 Ave Suite 250* **Please Fax to (954) 843-9444**