DERMATOLOGY SURGERY CENTER

Scott Beals D.O., P.A.
4566 Hwy. 20 East, Ste. 101
Phone: (850) 897-7546 Niceville, FL 32578 Fax: (850) 897-7547

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____/_____/_____

Address: _____

City/ State/ Zip: _____

Patient's phone #: (____) _____ VA Beneficiary Social _____-____-_____

RELEASE OF RECORDS: *(ALL PATIENTS HAVE FREE ACCESS TO THEIR PATIENT PORTAL ONLINE)*
******THERE IS AN ADMINISTRATIVE FEE OF $1 PER PAGE TO PROCESS ANY PRINTED OR FAXED RECORDS. THIS PROCESS CAN TAKE UP TO 10 BUSINESS DAYS******

☐ I authorize Dermatology Surgery Center to release information **to**:

_____
Name of Person or Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone # / Fax # (include area code)

DATES OF SERVICE: ☐ All

☐ or _____/_____/_____ through _____/_____/_____

INFORMATION TO BE DISCLOSED:
☐ Entire Record ☐ Pathology Report

☐ Office Visit Notes ☐ Surgical Notes

☐ Allowing another recipient full access to discuss patient records

Other: _____

REQUEST OF RECORDS

☐ I authorize Dermatology Surgery Center to obtain information **from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone # / Fax # (include area code)

Request of skin related Pathology reports and Surgical Notes:
Dates requested:
☐ All

☐ or _____/_____/_____ through _____/_____/_____

OTHER DOCUMENTS TO BE DISCLOSED:

☐ Entire Record ☐ Office Visit Notes

☐ Other: _____

*****IF MORE THAN 15 PAGES PLEASE MAIL TO OUR OFFICE***

PURPOSE FOR THIS REQUEST: ☐ Medical Care ☐ Insurance ☐ Personal

☐ Transfer of Care Reason: _____

☐ Other: _____

I understand that:
- My right to healthcare treatment is not conditioned on this authorization
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form except where a disclosure has already been made in response to a prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations your information could be re-disclosed and may no longer be protected by privacy law.
- There may be a charge for requested records.

Signature of Patient or Representative: _____ Date: _____/_____/_____

Relationship to Patient (if requester is not the patient): _____

Office Use Only: Faxed/Mailed: _____/_____/_____ Office Pick-Up: _____/_____/_____ Chart Notated: _____/_____/_____

Employee Initials: _____