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MIAMI, FL 33173
P: (305) 273-7998
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CIOCCADERMATOLOGY.COM

Authorization for Disclosure of Health Information

This form authorizes release of medical records from:

Physician Name: ____

Address: ____

City/State/ Zip Code: ____

Phone: (   ) - __________ - __________   **Fax: (   ) - __________ - ____________**

Purpose of PHI Disclosure request:
_______ **Patient Personal request**
_______ **Transferring patient**
_______ **Insurance**
_______ **Referral**

To be send via :
_____________ **Fax to (   ) - _________ - ________**

_____________ **Email:** ____

_____________ **Mail – Address:** ____

Physician Name: ____

Address: ____

City/State/ Zip Code: ____

Phone: (   ) - __________ - __________   **Fax: (   ) - __________ - ____________**

This signed release includes:
_______ **Complete Records**
_______**Lab Results**
_______**Visit Notes from __________ to ____________**
_______ **Pathology report**

By signing this agreement, I authorized Ciocca Dermatology to release medical information. This form will only be authorized for the person sign under, any other request will require a new form.

____   ____
Patient/Agent/ Guardia Signature   **Date**