1600 36th Street Suite B
Vero Beach, FL 32960
(772) 567-1164
Fax: (772) 567-1501

Authorization to Release Medical Information / Records

PLEASE PRINT CLEARLY

Patient name _____
Last First Initial

Date of Birth _____Social Security #_____Phone #_____

Release records FROM:

_____
Releasing Doctor

Address _____
Street

_____Phone_____
City State Zip

Release records TO:

_____
Recipient

Address _____
Street

_____Phone_____ Fax_____
City State Zip

Specify Records Requested: _____

Records Fee(Florida Statues 395.3025) *$1 per page up top 25 page thereafter, .25 cents per page plus applicable postage fees.*

MAIL TO (Name / Address): _____

FAX TO (Name / Fax #): _____

PICK UP (Phone number to call when records are ready for pick up): _____

Payment accepted Visa, Mastercard & Check payable to SelectSkinMD

Cardholder Name _____ Address_____

Credit Card Number_____ Exp date _____ CCV _____

I understand that I may revoke this consent any time prior to the actual sending of the medical information. I, the undersigned agree to all conditions set forth in this credit card authorization.

_____ _____
Patient or Legal Representative Signature **Date**