Dermatology Specialists of North Florida, P.A.
John P. Kartsonis, M.D. | 7711 Baymeadows Road East, Suite 6 | Jean H. McClintock, M.D.
Jacksonville, FL 32256
Phone (904) 731-1770
Fax (904) 996-8300

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: Birth Date:

Address: SSN:

Phone:

The following information is to be released FROM: Dr. ____

(Phone: ______________________________Fax: ______________________________)

___ **COMPLETE HEALTH RECORD** ___ Laboratory Reports ___ Other Medical Information:
___ Consultation ___ Pathology Reports ______________________

DATES OF SERVICE:
All dates of service _____ OR from _______________ to _______________

This information is to be released TO:
Dr. ____ Fax: ______________________________

FEE SCHEDULE: $1.00 per page unless released to treating Doctor/Treatment Facility

- I understand that my complete medical record will include any office notes, lab tests and/or pathology reports and x-ray reports. I understand that there may be medically sensitive information in my medical record that my include information relating to sexually transmitted diseases, AIDS (Acquired Immunodeficiency Syndrome), or infection with HIV (Human Immunodeficiency Virus). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.
- I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand that the revocation will not apply to information already released based on this authorization.
- I understand that authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research may be denied.
- I understand that I may inspect or obtain a copy of the information to be used or disclosed.
- Unless otherwise revoked or specified, this authorization will expire twelve (12) months from the date listed below.

I have read and understood this authorization.
I hereby authorize the release of the above-requested medical information.

_______________________________________ _______________________________________
Signature of Patient Date Signature of Patient's Authorized Representative