# Dermatology SouthEast
ST. JOHNS

## Authorization to Release Information

Please Print Clearly

Name: _____ Date of Birth: _____
(last) (first) (initial)

Address: _____
(street) (city) (state/zip)

Phone #s: _____

For Disclosure Only, I hereby authorize:

Physician/Practice Name: _____ Phone: _____

Address: _____ Fax: _____

To disclose medical record information and/or protected health information of the patient listed above to:

**Arianne Chavez-Frazier, M.D. Dermatology Southeast**
**616 State Rd 13, Suite 8, St. Johns, FL 32259**
**Phone: 904-512-1899 Fax: 904-770-7592**

□ Entire Record
□ Specific Information: _____

_____

Reason for Request: _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and provides no long-term protection.

Fees will comply with all laws and regulations applicable to release of information.

I have read the above and authorize the disclosure of protected health information as stated.

_____ _____
Signature of Patient (if not patient, state relationship) Date

_____
Witness Signature