Brevard Skin & Cancer Center

AUTHORIZATION FOR REQUEST OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:** _____

Address:_____

1. I hereby authorize_____Address:_____

City: _____ St:_____ Zip: _____ Phone: _____ Fax:_____

To disclose the following information from the health care records on the above name.

2. The type of information to be disclosed: (check all boxes that apply)

_____history and physical **_____office notes** **_____ pathology reports**

_____lab results **_____operative reports** **_____entire medical records**

3. Please specify the dates of service you are requesting the above information **FROM _____ TO_____**

4. If applicable, I also give permission for the following to be disclosed.
_____ acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
_____ behavioral health services/psychiatric care
_____treatment for alcohol and/or drug abuse

5. This information should be disclosed to: **BREVARD SKIN AND CANCER CENTER**
_____ 1286 S. Florida Avenue, Rockledge, FL 32955 Fax: 321-636-1152
_____ 4500 S, Hopkins Avenue, Titusville, FL 32780 Fax: 321-267-9117
_____ 8059 Spyglass Hill Rd, Ste. 103, Viera, FL 32940 Fax: 321-752-5494

6. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Brevard Skin and Cancer Center where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days.

7. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. If I have questions about disclosure of the information, I can contact the Brevard Skin and Cancer Center records administrator in Rockledge.

Signature of Patient or legal representative: _____ Date: _____

FOR OFFICE USE ONLY

Verified identity using: [ ] Driver's License [ ] Work/Gov't ID
[ ] Company/Agency letter [ ] Other: _____

Acct.# _____

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