GREATER MIAMI
Skin & Laser Center

4308 Alton Road, Suite 750 Miami Beach, FL 33140
Ph: 305.532.4478 Fax: 305.532.9753

MEDICAL RECORDS RELEASE FORM

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Phone number: _____

_____
City State Zip Code

I DO HEREBY CONSENT AND AUTHORIZE: The Greater Miami Skin and Laser Center to disclose protected health information about me to: _____

Name of physician, practice, facility, or person(s) where records will be sent.

TO RELEASE MY MEDICAL RECORDS FOR THE FOLLOWING PROCEDURE(S):

_____

ON THE DATE(S) OF SERVICE: _____

Please select a delivery method for your medical records:

☐ Regular mail **(OR)** ☐ Fax

_____ _____
Mailing address *Fax Number*

_____
City/ State/ Zip

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

THEREFORE, COMPLYING WITH HIPPA REGULATIONS WITH SPECIFIC INSTRUCTIONS, THIS PERMISSION EXPIRES ON: _____
Expiration Date

Please Fax your request to: (305)532-9753
Attention: Medical Records