



**13691 Metropolis Avenue  
Fort Myers, FL 33912  
Phone (239) 561-3376 Fax (239) 561-3020**

**RELEASE OF MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

I hereby request and authorize: **FLORIDA SKIN CENTER**

To release copies of my medical records to (Clinic Name and Address Here):

\_\_\_\_\_  
\_\_\_\_\_

Type of information to be disclosed (type of illness/injury/treatment):

\_\_\_\_\_  
\_\_\_\_\_

Attending Physician(s): \_\_\_\_\_ Approximate date(s) of care: \_\_\_\_\_

The information is needed for the purpose (check appropriate):

Insurance     Legal     Medical     Other: \_\_\_\_\_

I understand that I may revoke this consent at any time, and that this authorization will automatically expire in 12 months form the date of my signature.

\_\_\_\_\_  
Signature of patient or guardian and their relationship to patient

\_\_\_\_\_  
Date

Please give the reason that someone other than the patient is signing:

\_\_\_\_\_