

# MacInnis Dermatology

27950 US Hwy 27, Leesburg, FL 34748

Phone (352)350-5230 Fax (866) 539-7193

17521 US Hwy 441, Suite 21, Mt Dora, FL 32757

www.macinnisdermatology.com

1950 Laurel Manor Drive, Suite 124, The Villages, FL 32162

Visit your portal ~ <http://macinnisderm.ema.md>

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, \_\_\_\_\_  
*Print Patient's name*

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

**Authorize:** Name: \_\_\_\_\_

Address \_\_\_\_\_

City, State, & Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

To release a **COPY/SUMMARY** of my medical records to:

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

Address \_\_\_\_\_

City, State, & Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

I understand that the specific reports disclosed shall include (last labs, biopsy):

\_\_\_\_\_  
\_\_\_\_\_  
*(Note: If your records are to include AIDS/HIV status, mental health records or drug/alcohol history, you must list them in the space above)*

I understand that this consent is revocable upon written request to the practice, except to the extent that action by the practice has been taken in reliance on this authorization and that this authorization shall remain in force for a reasonable time in order to effect the purpose for which it is given.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*THIS RELEASE FORM IS ONLY GOOD FOR 1 YEAR FROM DATE SIGNED\*\*\*