(Records to be released TO our office)

FROM: A Center for Dermatology, Cosmetic and Laser Surgery
Peter Vitulli Jr., D.O., F.A.O.C.D. , F.A.A.D.
Board Certified Dermatologist ● Board Certified Mohs Surgeon
4600 Military Trail, Suite 107, Jupiter, FL 33458
Ph.: 561-427-2000 ● Fax: 561-776-2565

Patient authorization for Using, Receiving, Disclosing, and Utilization of protected health information

_____ _____ _____
Patient Name (print) Date of Birth Today's Date

By signing this information, I authorize to release my records to, A Center for Dermatology, Cosmetic & Laser Surgery. This authorization permits:

Name:_____
Address:_____
_____
Phone:_____ Fax: _____,

to disclose the following individually identifiable health information about me. Please specifically describe the information to be used, received or disclosed, such a date(s) of service, types of service, level of detail to be released, origin of the information, etc.:

_____
_____

The information will be used for the following purpose: _____
This form will expire on: _____ **(will automatically expire 30 days from this date if not specified)**
When my information is used, received, or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance to this authorization. My written revocation must be submitted to the privacy officer at 4600 Military Trail, Suite 107 Jupiter, Florida 33458

Signed by: _____ _____
Signature of patient or legal guardian Relationship to patient

Print Name: _____ Witness: _____

Revised 8/19