Thi T. Tran, DO, FAOCD, FAAD
Board Certified Dermatology
Board Certified Mohs Micrographic Surgery

Village Dermatology & COSMETIC SURGERY, LLC

Skin Cancer
And Mohs Surgery Specialist

AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION

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

I authorize the release of medical information as indicated below:

From: _____ **Phone:** _____
Address: _____ **Fax:** _____
_____

☐ I would like to have my records mailed to Village Dermatology & Cosmetic Surgery, LLC | **1950 Laurel Manor Drive, Bldg. 220, Suite 224 The Villages, FL 32162**

☐ I would like to have my records faxed to Village Dermatology & Cosmetic Surgery, LLC | **Fax 352-205-7777**

Records to be released: **List date(s) below:**

☐ Office Notes _____
☐ Consultation Notes _____
☐ Pathology/Biopsy Report _____
☐ Other _____

Purpose of the release:

☐ Verification of treatment
☐ Medical History
☐ Other: _____
☐ Open Pathology/Biopsy Report

May not include mental health treatment records, psychological services and social services information, including communicate made by patient to a social worker or psychologist.

May not include HIV/AIDS, substance abuse or generic information except for any of this additional information that I include below.

_____

Expiration date: This authorization shall expire in 14 days. After this date, Village Dermatology & Cosmetic Surgery, LLC, can no longer use or disclose patient's protected health information without first obtaining a new authorization form.

I understand this Authorization can be revoked at any time according to Village Dermatology & Cosmetic Surgery, LLC's privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Village Dermatology & Cosmetic Surgery, LLC and may potentially be re-disclosed by the party who received these records. Village Dermatology & Cosmetic Surgery, LLC, its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

_____ _____
Signature of the patient Date

_____ _____
Signature of legal representative and relationship to patient Date