INTEGRATED DERMATOLOGY OF EAST BOCA

PLEASE SEND THE BELOW FORM EITHER BY FAX TO NUMBER 1-888-573-0231, BY EMAIL TO ADDRESS idgebgen@mydermgroup.com (*Please be advised that email is not a secure method and by submitting a request via this method you are assuming all risks.*) OR BY MAIL Integrated Dermatology of East Boca c/o Dermatology of Boca 4601 N Federal Hwy Boca Raton FL 33431.

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

PATIENT PHONE NUMBER: _____

Dear Integrated Dermatology of East Boca Records Department:

Please release a copy of all of my health information that the practice has in its possession as directed below. I understand the information to be released or disclosed may include information relating to any medical history, mental or physical condition and any treatment received by me, including (to the extent applicable) any HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records:

Please check one:

1. ___ MAIL (Please provide the address below)

_____

_____

2. ___ FAX (Please include a working fax number and applicable "attention to:" information

_____

Fax Number

_____

Attention to

3. ____EMAIL (**Please be advised that email is not a secure method to send confidential information and by checking this box you are assuming all risk associated with sending medical records through email)**

email address:_____

Thank you,

_____

Signature of patient or legally authorized representative

_____ _____

Print Name Date