SKIN WELLNESS
PHYSICIANS

AUTHORIZATION TO RELEASE/OBTAIN HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

❖ For the purpose of patient care, I hereby request and authorize Skin Wellness Physicians to release my medical records to:

Name of organization or individual: _____

❖ I request/authorize _____ to release the healthcare information of the patient named above to:
(name of organization or individual)

Skin Wellness Physicians

1300 Goodlette Rd. N.

Naples, FL 34102

Phone: (239) 732-0044 Fax: (239) 732-0094

This Request/Release applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

_____

☐ All healthcare information

☐ Other: _____

Non – expiring release _____ This release expires _____ from date of signature

I understand that my authorization will remain effective as indicated above and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

Patient/Representative signature: _____ Date: _____

Relationship to Patient: _____