Skin & Cancer Associates
4308 Alton Road, Suite 510
Miami Beach, FL 33140

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____

Date of Birth:_____/_____/_____

Please select all that apply:

_____Please DO NOT release ANY medical information to anyone other than Myself.

_____I authorize this office to discuss my medical care with the following:

Name:_____ Relationship:_____

Tel.:_____

Name:_____ Relationship:_____

Tel.:_____

Witness:_____ Date:_____