

**Palm Beach Physicians Group, Inc.
dba Palm Beach Medical Group
Authorization for Release of Information**

PATIENT NAME: _____
 DATE OF BIRTH: LAST _____ FIRST _____ MI _____ MAIDEN OR OTHER NAME _____
 SS#: _____ MEDICAL RECORD #: _____
 MO DAY YR
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize Palm Beach Medical Group to release information from my medical record as indicated below to:

NAME: John P. Kinney, MD at Palm Beach Dermatology, Inc.
 ADDRESS: 4477 Medical Center Way CITY: West Palm Beach STATE: FL ZIP: 33407
 PHONE: 561-840-7977 FAX: _____

INFORMATION TO BE RELEASED:

All records relative to dermatology care provided by John P. Kinney, MD inclusive of progress notes, lab reports, and biopsy reports.

I specifically authorize the release of information relating to:	
<input type="checkbox"/>	Substance abuse (including alcohol/drug abuse)
<input type="checkbox"/>	Mental health (including psychotherapy notes)
<input type="checkbox"/>	HIV related information (AIDS related testing)
<input checked="" type="checkbox"/>	_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN	DATE

PURPOSE OF DISCLOSURE: Changing physicians Consultation/second opinion Continuing care
 Legal School Insurance Workers Compensation
 Other (please specify): _____

- I understand that this authorization will expire **90 days** after I have signed the form.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand that in compliance with Florida Statute, I will pay a fee of \$1.00 per page up to 25 pages and 25 cents per page thereafter. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

 SIGNATURE OF PATIENT DATE OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

 RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY	
DATE REQUEST FILLED: _____	BY: _____
IDENTIFICATION PRESENTED: _____	FEE COLLECTED: \$ _____

*It is our policy to fulfill requests for information within 30 days of receipt of a valid
 Authorization for Release of Information Form*