SPENCER DERMATOLOGY
MOHS SKIN SURGERY CENTER

Consent to Release Medical Information

Patient: ________________________________ DOB ______/______/_______

Physician/Person releasing / receiving information(circle one)**-**

Name: ____

Address: ____

City/State/Zip: ____

Phone: ____________________ Fax: _____________________

□ *I would like my records emailed. Address:____*
By checking this box, I understand that email is NOT a secure form of transmission and I will not hold Spencer Dermatology liable should my information be intercepted.

Physician/Person receiving / releasing medical records-

Spencer Dermatology & Skin Surgery Center
James M. Spencer MD, MS
Joanne Mongtomery MD
Scott Freeman PA-C
900 Carillon Parkway
Suite 404
St. Petersburg, FL 33716
727-572-1333
727-572-1331 fax

Medical information to be sent:
Any information including diagnostic and medical records or treatment/exam rendered to me during the period from _____________ to ______________, to include any and all federal and state protected information including, without limitation, psychiatric, drug and/or alcohol abuse and human immunodeficiency results (Aids and related conditions). You are authorized to use outside vendors for the purpose of copying and providing the information requested.

I understand and direct that this authorization is in effect for 90 days or until I revoke it in writing. I hereby release Spencer Dermatology, its employees and vendor (including vendors, employees and independent contractors) from any and all liability that may arise from the release of this information as I have directed.

____ _____________________________
Patient name in full (Print) Date

____
Patient Signature

_______________________________________ _________________________________
Authorized Representative Witness