**Jon Ward, M.D.**
*Fellow, American Academy of Dermatology*
*Fellow, American Society of Mohs Surgery*

**Michael Stickler, M.D.**
*Fellow, American Academy of Dermatology*
*Fellow, American Society of Mohs Surgery*

Nichol Raulerson, PA-C | Heather West, PA-C | Laura Gilmore, PA-C
Angela Franz, PA-C | Barry Newton, PA-C

| | | | | | |
|---|---|---|---|---|---|
| 2505 Harrison Avenue | 12111 Panama City Bch Pkwy | 141 Mack Bayou Loop, Suite 202 | 4378 Lafayette Street | 2600 Hospital Drive | 212 NW Racetrack Road |
| Panama City, FL 32405 | Panama City Bch, FL 32407 | Santa Rosa Beach, FL 32459 | Marianna, FL 32446 | Bonifay, FL 32425 | Ft Walton Beach, FL 32446 |
| phone 850-233-3376 | phone 850-233-3376 | phone 850-622-0600 | phone 850-526-7546 | phone 850-233-3376 | phone 850-233-3376 |
| fax 850-522-8354 | fax 850-522-8354 | fax 850-522-8354 | fax 850-522-8354 | fax 850-522-8354 | fax 850-522-8354 |

# MEDICAL RELEASE CONSENT

Patient Legal Name: ____________________ Birth Date: ____________ Social Security No. ____________

Patient Address ____________________ Telephone No. ____________

City ____________ State ______ Zip Code ____________

***For Disclosure Only***
I hereby authorize ________________________________________
Physician and Practice Name/Title

________________________________________
Address

________________ Fax Number ________________ Telephone Number

To disclose medical record information and/or protected health information of the patient listed above to:

________________________________________ ________________
Physician and Practice Name/Title Telephone Number

Purpose:________________________________________

***Type of Access Requested :***

- ☐ Copies of the record
- ☐ Inspection of the record
- ☐ Entire Record

***Select Portions of Personal Health Information :***

- ☐ Emergency Room
- ☐ History & Physical
- ☐ Consult Report
- ☐ Operative Report
- ☐ Lab
- ☐ Imaging / Radiology
- ☐ Demographics
- ☐ Progress Notes
- ☐ Medication Record
- ☐ Path Report
- ☐ Physician Orders
- ☐ Billing Records
- ☐ Other________________

***Expiration : This authorization shall expire upon (check one) :***

- ☐ Fulfillment of this request (according to HIPAA or State Regulations, whichever is shorter)
- ☐ Date ________________

I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

Fee/changes will comply with all laws and regulations applicable to release of information.

I have read the above and authorize the disclosure of the protected health information as stated

________________ ________________________ ________________
Date Signature of Patient/Responsible Party Relationship to Patient

________________________________________
Address and telephone number of Requestor (if different from patient information)