Advantage Dermatology, P.A.

1514 Nira Street • Jacksonville, Florida 32207 • Phone: 904-387-4991

MEDICAL RECORDS AUTHORIZATION

***Please fax to our Medical Records Request Line: 904-306-5778**

I hereby authorize Advantage Dermatology, P.A. to disclose the information described below. I understand that it may take up to thirty (30) days to process my request before my records are available for pickup.

Patient Information	Full Name:______________________________ Date of Birth: ____________ SSN:______________________ Insurance(s):______________________________
Recipient Information	Name:______________________________ Address:______________________________ ______________________________ Telephone Number:______________________________
Purpose for Request	☐ Moving/Relocating ☐ Attorney ☐ To Another Physician ☐ At Request of the Patient ☐ Insurance/Insurance Policy ☐ Other______________________
Requested Information	☐ Laboratory Reports Only ☐ Billing Information Only ☐ Medical Record from ____________[Year] to ____________[Year] ☐ Entire Medical Record ☐ Other______________________________
Form	☐ In Office Pickup ☐ Mail ☐ Fax

EXPIRATION DATE: This authorization will expire ***thirty (30) days*** from the date listed at the top of this form unless a different expiration date or expiration event is written here:______________________.

REVOCATION: I understand that I have the right to revoke this authorization in writing any time, however I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the Practice shall not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign this form. I understand that the revocation will not apply to my insurance company, Medicaid, and Medicare when the law provides by insurer with the right to contest a claim under my policy. Written notice should be directed to Advantage Dermatology, P.A.'s Privacy Officer.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

SIGNATURE:______________________________ **DATE:**____________________

☐ Patient

☐ Personal Representative. Please explain the authority to act for the patient______________________

OFFICE USE ONLY		
Date Received ____________	**Date Sent** ____________	**Initials** ____________

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FEES FOR MEDICAL RECORDS AND COMPLETION OF MEDICAL DOCUMENTATION

Pursuant to your request for copies of your medical records, please be advised that the Practice charges the following amounts for reproduction of paper medical records, in accordance with the rules governing the Florida Board of Medicine.[1] The Practice may condition the release of the requested document upon payment for the records by the requesting party as set forth below. If the requesting party is the patient, and there are special circumstances regarding the patient's economic status or ability to pay for physical copies of your records, please let us know and we will make every attempt to accommodate you. Review and completion of forms such as cancer policies, FMLA paperwork, or STD paperwork require additional activity beyond printing the medical record. These forms will be completed and provided to the requestor upon payment of the fees set forth below. *Electronic copies of the visit notes can be viewed and downloaded by Practice patients at any time after logging into the Secure Online Patient Portal. These records are available at no charge when accessed by the patient through the Secure Online Patient Portal. Please see the Practice website for additional information.

1) **General Medical Records Requests**
   a. For patients and governmental entities:
      i. $1.00 per page for the first 25 pages.
      ii. $0.25 per page for each page in excess of 25 pages
   b. For other entities:
      i. $1.00 per page.
2) **Completion of Cancer Policy Forms/Codes $25.00**
3) **Completion of FMLA Paperwork $25.00**
4) **Completion of STD Paperwork $25.00**

Requests and payments for medical records may be made via check to the address below. Please indicate "Medical Records" in the notes section of your check. If you would like to make a credit card payment by phone, please contact our billing department at 904-387-4991 Ext. 2039. ***Please keep in mind that it may take up to thirty (30) days to process your request.***

- Advantage Dermatology, P.A.
  ATTN: Medical Records Department
  1514 Nira Street
  Jacksonville, Florida 32207

I have read and reviewed Advantage Dermatology, P.A.'s Policy on Fees for Medical Records and Completion of Medical Documentation.

____
Signature

____
Printed Name

____
Date

Office Use Only
Payment Received: ___Yes ___No
Form of Payment: ___Check ____ Credit Card
Total # of Pages_______________
Total Amount Due ______________
Was the requestor a patient/government entity? ___Yes ___No
Notes:

[1] 64B8-10.003 F.A.C.