HIGH TIDE DERMATOLOGY CENTER

Debra L. Bailey, M.D.

Authorization for Release of Medical Records

RECORDS TO: _____

_____

_____

RECORDS FROM: _____

_____

_____

PATIENT INFORMATION (Please Print):

Name: _____

Date of Birth: ____/____/____ Phone: ____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Reason for Request: _____

I request a copy of all medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests. **(NOTE: Copy and Preparation Fees may apply.)**

MAIL/FAX TO: High Tide Dermatology Center / 2350 Vanderbilt Beach Road, Suite 301 / Naples, FL 34109 / FAX: 239-316-3001

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

PATIENT/GUARDIAN _____ **Date** _____
Signature

WITNESS_____ **Date** _____
Signature

SUPERVISING PHYSICIAN_____ **Date** _____
Signature

2350 Vanderbilt Beach Road • Suite 301 • Naples, FL 34109
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www.naplesdermdoc.com