BRADENTON
Skin Cancer

250 2nd St. East; Suite 4C Bradenton, FL 34208
Phone: (941) 744-5860 Fax (941) 744-5681

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient:_____

Date of Birth:_____ **S.S.# :** _____

I hereby authorize the release of my medical records and information by:

_____

Doctor/Practice Name **Phone Number**

_____

Address **City** **State** **Zip Code**

I understand my medical records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my expressed written authorization unless otherwise provided for in the regulations.

Please forward my records to: Ted F. Kadivar, MD PA via fax to 941-744-5681.

Records needed:

☐ **Office Visit Notes** ☐ **Pathology Reports**

This authorization will expire in 60 days unless otherwise specified by me.

_____ _____

Signed **Date**

_____ _____

Witness **Date**