



A Division of Premier Dermatology

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**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
(Please Fax Records to 941-795-1400)**

I, _____ DOB: _____
(Patient's Name)

Hereby authorize Kate Gerber M.D and Associates to: (check one option)

- release copies of my medical records
- obtain all my records

For the purpose of fully evaluating my health and to make informed decisions. Please include the following protected information in addition to my general health information: (check applicable option)

- All labs, imaging studies, and records
- Pathology
- Photos
- All Available medical records

TO/FROM: (circle one option) _____

Patient Signature:

Date: