



*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 (past 2 years only)
- All Available medical records

**TO/FROM:** (circle one option) \_\_\_\_\_

**Patient Signature:**

**Date:**

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