Charles R. Kovaleski, MD
Diplomate, American Board of Dermatology
Board-certified Dermatologist

Stephen Plumb, DO
Fellowship-Trained Mohs Surgeon
Fellowship-Trained Dermatopathologist
Board-certified Dermatologist
Board-certified Dermatopathologist
Board-certified Anatomic & Clinical Pathologist

DERMATOLOGY ASSOCIATES
SKIN & CANCER CENTER

(850) 769-SKIN (7546) • Fax (850) 785-2123
1900 Harrison Ave • Panama City, FL 32405

Robert J. Siragusa, MD
Diplomate, American Board of Dermatology
Board-certified Dermatologist

Christopher M. Wolfe, DO, FACMS
Fellowship-Trained Mohs Surgeon
Board-certified Mohs Surgeon
Board-certified Dermatologist

Bret Johnson, MD
Associate, American Board of Dermatology

Charles Byron, MPAS, PA-C • Kelly Wood, MPH, PA • Mary Carmon, APRN
• Jenny Owens, APRN • Adrienne Keely, APRN • Barry Newton, PA-C

Patient Name: _____ Date of Birth: _____

Address: _____ SSN: _____

Requesting Records From: _____

Address: _____ Phone _____

To disclose to: **Dermatology Associates 1900 Harrison Ave, Panama City, FL 32405**

850-769-7546 (Office) 850-785-2123 (fax)

If over 10 pages please mail

The following information:

- ☐ All medical records
- ☐ Lab results
- ☐ Last office notes
- ☐ Surgical/Pathology results

Dates of information to be disclosed: From _____ to _____
(If left blank, only information from the past two (2) years will be disclosed)

Purpose of request:

- ☐ Further medical care
- ☐ Legal purposes
- ☐ Personal (at my request)

YOUR RIGHT WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authoriztion. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

Signature of patient/legal guardian: _____ Date: _____

Witness: _____