BRACCIANO DERMATOLOGY
Authorization For Release of Medical Information

I Hereby authorize ____

____
(Individual or organization holding the health records)

To disclose information from the health records of:

Patient Name ___________________________________ DOB ____________

Address ________________________________ Phone __________________

This information is to be disclosed to:

David M. Bracciano, D.O.
8430 Cooper Creek Blvd., Suite 102
University Park, FL 34201
Phone: 941-360-2255
Fax: 941-487-1777

OR ______________________
____
____
____

Information to be disclosed:

_____ Complete Medical Records
_____ Skin Biopsy Reports
_____ Lab Reports
_____ Surgical Procedures
_____ Other

I give my permission for the release of the above-mentioned information.

______________________________________ ______________
Signature Date