GREENSBORO DERMATOLOGY ASSOCIATES, PA

CONSENT TO RELEASE MEDICAL RECORDS

FROM: Patients Name _____

Patient's Address _____

Patient's Birth Date _____

Patient's Social Security Number _____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. **PLEASE NOTE**: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV Testing, AIDS, and any AIDS-Related Syndromes. It also includes any information concerning Cancer, Cancer Testing, and Cancer Results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

SEND ALL MY RECORDS YES NO (if no send only items marked below)

Office Notes _____ Labs _____ Correspondence _____

OP Notes _____ Path Reports _____ Other _____

SEND RECORDS FROM (DATE) _____TO (DATE) _____

SEND RECORDS TO:

_____

_____

_____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will remain in collect.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Patient s Signature

_____

Date

_____

Witness

2704 St. Jude Street • Greensboro, N.C. 27405-3670 • P.O. Box 14962 • Greensboro, N.C. 27415-4962
Telephone: (336) 954-7546 • Medical Records Fax: (336)-954-9898 • Clinical Fax: (336) 235-4018