WAKE DERMATOLOGY ASSOCIATES, PA
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MEDICAL RECORDS RELEASE FORM

I DO HEREBY CONSENT AND AUTHORIZE:

_____

Name/Office

_____

Address

TO RELEASE copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are 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.

- o send all of my records
- o send dates from _____ to _____
- o send only pathology reports

SEND RECORDS TO:

_____

Name/Office

_____

Address

_____

Patient Name Date of Birth

_____

Signature of Patient/Parent/Legal Guardian Telephone Number