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Dermatology Center of Williamsburg

MEDICAL RECORD RELEASE

Patient's Name: _____
DOB: _____ Social Security#: _____
Home Address: _____ City, State, Zip _____

I AUTHORIZE DERMATOLOGY CENTER OF WILLIAMSBURG TO:

☐ Obtain Information From: ☐ Release Information To:

Name of Physician/Facility: _____
Address: _____ City, State, Zip _____
Phone: _____ Fax: _____

REASON FOR REQUEST:

☐ Transferring to a new physician
☐ Moving to new address
☐ Records requested by specialist
☐ Other (please specify) _____

INFORMATION TO BE PROVIDED:

☐ Entire medical record
☐ History and Physical
☐ Progress Notes
☐ Laboratory Reports
☐ Pathology Reports
☐ X-ray Reports
☐ Medications
☐ Consultations

☐ Other (please specify) _____

I understand that this release is valid for one year from the date of signature below, and that I may revoke this release at any time by notifying Dermatology Center of Williamsburg in writing. The revocation will only be effective from the date it is received by Dermatology Center of Williamsburg and will not apply retroactively.

_____ _____
Signature of patient or parent or parent/guardian if minor Date:

_____ _____
Printed name of patient or parent/guardian if minor Date:

IN OFFICE USE ONLY

Records sent: _____

Physician Signature: _____

Date Faxed/Mailed: _____ Initials: _____