**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**Patient Name:_____Date of Birth:_____**

**___All (Notes, labs, pathology)** **Date_____**

**___Progress Notes** **Date_____**

**___Pathology Reports** **Date_____**

**___Lab Reports/Results** **Date_____**

**FROM:** **Current Dermatology**
**61 Bonnie Lane**
**Sylva, NC 28779**
**Phone (828)631-1852 Fax (828)631-2534**

**RELEASE INFORMATION TO:_____**

**Address:_____**

**Phone:_____ FAX:_____**

**Release information by: __ Mail __Fax (_____-_____-_____)**
**Pick up in-office_____Other_____**

**I hereby authorize disclosure of the above named patient. This authorization is valid until I revoke it in writing and will not take any effect on any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person/class of persons/facility receiving it and would no longer be protected by federal regulations. I understand that the medical provider to whom this information is furnished may not condition their treatment of**

**_____** **_____**

**Signature of patient or legal representative** **Date**

**Office Use only_____**

Request fulfilled by Staff:_____ Date_____