ASHEVILLE
DERMATOLOGY
PROFESSIONALS

MEDICAL RECORDS RELEASE FORM

Patient Name:____ DOB:___/___/___

Street:____

City: ______________________________ State: ___________ Zip: _________________

Home Phone: (_______)____________________ Patient Cell: (_______)______________________

INFORMATION TO BE RELEASED FROM:

Physician/Practice:____

Street:____

City: ______________________________ State: ___________ Zip: _________________

Phone: (_______)_________________________ Fax: (_______)___________________________

PATIENT AUTHORIZATION:

You may disclose the following health care information:

☐ **ALL my health information** (including, but not limited to, progress notes, laboratory results, imagining results, HIV/AIDS and other communicable disease information, behavioral health information, alcohol and/or drug abuse treatment, if any,) **unless specifically excepted**:____________________________
____

OR

☐ My health information **only for the following visit dates**: _______________ to ______________

INFORMATION TO BE RELEASED TO:

ASHEVILLE DERMATOLOGY PROFESSIONALS
900 HENDERSONVILLE RD
SUITE 107
ASHEVILLE, NC 28803
PHONE: 828-482-7300
FAX: 828-482-7373

Please ☐ Mail ☐Fax my records

This authorization is valid for one year from the date of signing and may be revoked at any time prior to one year by providing written notice. I understand that I cannot retroactively revoke this authorization for information already released.

_______________________________________ Date: _____/_____/_____
Patient Signature

_______________________________________ Date: _____/_____/_____
Witness Signature