Family Dermatology
A Division of Raleigh Medical Group

Diseases and Surgery of the Skin, Hair, and Nails
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MEDICAL RECORDS RELEASE FORM

Patient Name: ____
Date of Birth: ____________________ Phone Number: ______________________________
Street Address: ____
City: ________________________ State: ____________ Zip Code: ________________

Release Records From:
Name: ____
Address: ____
City: ________________________ State: ____________ Zip Code: ________________
Phone Number: ____________________________ Fax Number: ______________________

The specific information that I wish to have released is:

- All Clinical Medical Records
- Other Records—please list (e.g. billing, photographs, etc.)

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This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

- I consent to have the above information released.
- I do not consent to have the above information released.

Signature:____ Date: ______________

(Parent or Legal Guardian of Minor)

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

- I consent to have the above information released.
- I do not consent to have the above information released.

Signature:____ Date: ______________

(Parent or Legal Guardian of Minor)

I understand that this authorization will expire one year from the above date unless I specify an expiration date of ____________(place the expiration date in the blank field provided). I may revoke this consent at any time through written notice.
Family Dermatology has 30 days from the date of the request listed above to comply with the request for release of medical records.

Release Records to:
Name: ____
Address: ____
City: ________________________ State: ____________ Zip Code: ________________
Phone Number: ____________________________ Fax Number: ______________________

Witness Signature: ____ Date: _______________