DARST DERMATOLOGY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO OTHER PRACTICE

I authorize:

DARST DERMATOLOGY
11301 Golf Links Drive North, Suite 203
Charlotte, NC 28277

TO RELEASE MY MEDICAL RECORDS TO:

Name of physician/office: _____

Address: _____

City State Zip Code

Phone: _____

Fax: _____

Patient Signature: _____ Date: _____

Patient Printed Name: _____ Date of Birth: _____

INFORMATION TO BE RELEASED: (Check all applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ Path

RECORDS FROM THE PERIOD: _____/_____/_____ to _____/_____/_____

PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal

☐ Personal ☐ Life Insurance ☐ Other: _____

I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

The requestor may be provided with a copy of this authorization.