MEDICAL RECORD RELEASE FORM

DERMATOLOGY ASSOCIATES, P.A.
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STEVEN VERNALI, M.D. BRADLEY ALSIP, PA-C

DATE: _____

TO: _____ **FAX:** _____

By signing this form, I authorize the release of confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility/entity listed below.

PATIENT NAME: _____ **DOB:** _____

The information you may release subject to this signed release form is as follows:

☐ Complete Records
☐ History & Physical
☐ Lab Reports
☐ Operative Reports
☐ Pathology Reports
☐ Progress Notes
☐ Other *(please specify)* _____

From treatment date(s) _____ to _____

I authorize my health care information to be released to the following recipient(s):

Name: _____

Address: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

SIGNATURE: _____ **DATE:** _____
(Patient or legal relationship to the patient)

WITNESS: _____ **DATE:** _____