

Carolina Dermatology, LLC Authorization to Release Patient Information

Patient Name:	Maiden/Other Name:
Date of Birth:	SSN:
PATIENT Records From:	
Physician/Medical	Office
Address	
City / State / Zip	
Telephone	
Complete Medical Lab Reports Billing Statements	Consultation ReportsMedication/Allergies
Surgical Procedur	te date(s) of service listed:(MM/DD/YY) to(MM/DD/YY) te for the date of service listed(MM/DD/YY) the date of service listed(MM/DD/YY)
Please send my records to:	
Physician/Medical	Office
Address	
City / State / Zip	
Telephone Photocopies or facsimile o	f this Release shall be considered to be the same as a signed original document.
Signature:	Relationship:
Witness:	Date:
Please check if applicable:	A copy of Power of Attorney is on file I have Power of Attorney for the above named patient and am sending a copy
	Office Use Only - Do Not Write Below This Line
Released to:	Date: By:
Method: Mail	Fax Personal Pick Up By Signature Person