



harrisonburg
dermatology

REQUEST FOR RECORDS RELEASE

Physician's Name: _____

Phone Number: _____ Fax Number: _____

Street Address (if being mailed): _____

City: _____ State: _____ Zip: _____

Dear Doctor _____:

_____ The following individual has asked us to release his/her records **to** your office. We have included all relevant information from our files.

_____ The following individual has asked us to request his/her medical records **from** your office, please include all relevant medical records in your file.

Patient Name: _____ DOB: _____

I hereby authorize the release of all necessary medical records to/from Harrisonburg Dermatology, Jerri Alley, M.D.

Patient's Signature: _____ Date: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Reason for release of records: _____

For office use

Signature of Witness: _____ Date: _____

Employee Completing Request: _____ Date: _____

This authorization shall be in effect for 90 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the facility. A photocopy of this authorization shall constitute a valid authorization.

4549 Spotswood Trail, Ste 8
Penn Laird, VA 22846
Phone: (540) 433-8700 Fax (540) 433-8080