CAPITAL DERMATOLOGY OF NC

Authorization for Disclosure of Health Information

This form authorizes release of medical records from:

Practice Name: _____

Address:_____

City/State/Zip_____

Phone Number_____

Fax Number_____

To be sent to:

Capital Dermatology of NC
7209 Creedmoor Road · Suite 105
Raleigh, NC 27613
F 919.714.0909
Direct Message: royler@directaddress.net

From the records of:

X_____ X _____
Name of Patient Date of Birth

Please send the following information:

Check all that apply:
___X___All medical records
_____Operative Reports, applicable dates_____
_____Lab Reports, applicable dates_____
_____Pathology Reports, applicable dates_____
_____Other (specify)_____

The information contained herein is confidential and is being provided in response to a written authorization.

X_____ X _____
Patient or Legal Guardian Signature Date