HD 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 Alexiou, 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

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