Cary: (919) 363-7546 Fax: (919) 363-3616
Pinehurst: (910) 295-1761 Fax: (910) 295-2937

CARY SKIN CENTER

Authorization to Review or Release Health Information

Expires upon one time release

Patient Information:

Name of Patient _____Date of Birth _____

Address_____Phone_____

City, State, Zip

_____

I authorize the practice below to release my health information:
CARY SKIN CENTER, PA
200 Wellesley Trade Lane
Cary, NC 27519

Please forward/release my health information to:

_____

_____

_____

I request a copy or summary of the following medical records:

- ☐ Complete Medical Record
- ☐ Pathology Report(s) / Lab Report(s)
- ☐ Other as Listed:
- ☐ Office Visit Note(s)
- ☐ Operative Report(s)
- ☐ Information necessary to file cancer policy

_____

For dates of service from _____ to _____.

NOTE: Patient requests for medical records will incur a $15.00 fee payable prior to release of records.

This authorization shall be in effect until the information has been forwarded as requested.

_____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority (attach necessary documentation)

For Office Use Only

☐Records Faxed Date_____ Initials_____

☐Records Mailed Date_____ Initials_____

☐Records Emailed Date_____ Initials_____

☐Records Handed to Pt/Personal Representative Date_____ Initials_____