WILMINGTON
DERMATOLOGY
CENTER
710 Military Cutoff Rd. Suite 320
(910) 256-4350
(910) 239-5032 fax

Authorization for Use or Disclosure of Health Information
Please complete entire form to guarantee timely processing

Patient Name:_____ Date of Birth_____

Patient Address:_____

Home Phone Number_____ Cell phone_____

Person authorizing release of medical records Patient ____Parent/Legal Guardian_____Other _____

(Legal paperwork must accompany every release form if the requestor is not the patient or patient's guardian if the patient is under 18 years of age)

Records requested FROM:

Name of organization_____

Name of provider _____

Address _____

Address 2 _____

Phone # _____ - _____

Fax # _____-_____

Records to be SENT TO:

Name of organization_____

Name of provider _____

Address _____

Address 2 _____

Phone # _____ - _____

Fax # _____-_____

Please send : All records including lab work/biopsies _____ Please send : Records only (no lab work or biopsies) _____
Please send: Lab work/biopsies only _____Other:_____
Reason for Disclose or Use: Personal Use ____Changing Provider ____Insurance ____2nd Opinion____
Attorney _____Dissatisfied with Service _____Primary Care Review ____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices, practitioners, hospitals, and/or clinics that are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information related to pregnancy, sexually transmitted diseases, HIV testing, AIDS and any AIDS-related symptoms. It also includes any information concerning cancer, cancer testing and cancer results. I agree that a copy of this release shall be as valid as the original release. I understand the importance of following up with a dermatologist on a regular basis and I assume full responsibility for scheduling my own appointment with a dermatologist in the near future.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby give consent to the use or disclosure of my medical records for the purpose stated above.

Patient/Guardian Signature_____ Date_____

Witness _____ Date_____