



1203 TOWN PARK LANE
EVANS, GA 30809
PH 706.650.7546 • FAX 706.922.9168

CONSENT FOR RELEASE OF PATIENT INFORMATION

I, _____ (DOB: _____) authorize Dermatology Specialists of Augusta

To RECEIVE medical records from:

To SEND medical records to:

Though not required, it will help us improve our communication if the following question was answered. The purpose of my medical record request is:

- I am moving out of town.
- I need a copy for my personal records.
- I wish to change dermatologists.
- I wish to see a plastic surgeon.
- My insurance company requests a copy.
- Other: _____

I understand that these records will be handled in the most expeditious fashion possible. It is my responsibility to call to follow up that records have been transferred as requested. It is also my responsibility to seek further care for any outstanding conditions or malignancies.

I understand that there may be a charge for producing these records as allowed by state law.

If you are not the patient, please specify the relationship to the patient: _____

Signature

Date