

CONSENT FOR RELEASE OF MEDICAL RECORDS

Graham Dermatology

Dr Ana Benitez-Graham

202 Fieldale Road

Mebane, N.C. 27302

Phone: 919-304-5900 Fax: 919-304-5901

From: Patient's Name: _____

Patient's DOB: _____

Obtain Medical Records From: _____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. This authorization includes consent for the release of alcohol, drug, psychiatric: and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS. It also includes any information concerning cancer, cancer testing, and cancer results.

I agree that a copy of this release or a fax of this release shall be valid as this original release. Please send copies of all restricted information as soon as possible to the address listed.

Send All My Records

Send Records From {date} _____

Send Records To: _____

Patient's / Guardian's Signature

Date

Witness to Signature

Records Faxed _____

Records Mailed _____

Records Given to Patient