AZALEA
SKIN TREATMENT CENTER

MEDICAL RECORD RELEASE

Date: _____

Patient Name: _____

Date of Birth: _____ Chart #: _____

Address: _____

Home Phone: _____ Cell / Work Phone: _____

I hereby authorize the release of my medical records from:

Name of Practice: _____

Address: _____

City: _____State: _____Zip Code: _____

Phone: _____ Fax: _____

☐ Azalea Skin Treatment Center
501 Health Park Drive, Suite 150
Garner, NC 27529

SEND RECORDS TO:

☐ Azalea Skin Treatment Center
501 Health Park Drive, Suite 150
Garner, NC 27529

☐ Patient

☐ Name of Practice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Which records are being requested? (please circle) Pathology Report / Last Office Visit / Entire Chart

Patient or guardian's signature: _____

Witness: _____

Please check reason for obtaining medical records:

☐ Patient is moving
☐ Cancer policy
☐ Personal use
☐ Leaving our practice for another dermatology office
☐ Disability form
☐ Other
☐ Requested by another practice
☐ Life Insurance policy