Shenandoah Dermatology & Aesthetics

Staunton • Raphine • Fishersville
Waynesboro • Harrisonburg

PATIENT NAME: _____
LAST FIRST MI PREFIX/SUFFIX

OR FORMERLY KNOWN AS: _____

DATE OF BIRTH: _____ / _____ / _____

The information you may release subject to this signed release form is as follows:

- COMPLETE RECORDS
- DERMATOLOGY RECORDS ONLY
- PATHOLOGY
- LABS
- OTHER: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below:

	Shenandoah Dermatology, PC
To:	From:
	1600 N Coalter Street, Suite 19
Address:	Address:
	Staunton, VA 24401
City, State, Zip Code:	City, State, Zip Code:
	540-885-4500
Phone:	Phone:
	540-885-4600
Fax:	Fax:

I hereby authorize the release of medical records for myself or my minor child to be transferred:

Patient Signature: _____ Date: ____ /____ /_____

Parent/Legal Guardian Signature: _____ Date: ____/____/_____