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: ____ / ____ / ____

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