



**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: ____ / ____ / ____