1180 Resurgence Drive.
Suite 100
Watkinsville, GA 30677

GEORGIA SKIN CANCER
& Aesthetic Dermatology

Obtaining from:
Please **mail** records
larger than 20 pages.

Main Office: (706) 543-5858 **Medical Records Fax: (706) 621-5798**

MEDICAL RECORDS REQUEST/RELEASE FORM

Patient Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE GEORGIA SKIN CANCER TO: *INITIAL BELOW*

_____ **RELEASE INFORMATION TO**:	_____ **OBTAIN INFORMATION FROM**:

_____
Person or Entity or Name of Provider or Facility

_____
Address/City/State/Zip

_____
Phone Number Fax Number

Please *initial* specific information requested for release:

_____ Biopsy Results and Lab Reports – Specify, if needed: _____

_____ Dermatologic Surgical Procedures – Specify, if billing related: _____

_____ Medications/Prescription Plans

_____ Progress/Office Notes – Specify, if applicable: _____

_____ All Protected Health Information (PHI) in medical record

_____ Other: _____

For the purpose of: CHECK ONE

___ Healthcare Facility/Continuing Care
___ Legal
___ Personal
___ Disability
___ Insurance/Cancer Policy
___ Transferring Care
___ Physician
___ Other (Please specify): _____

I understand I may revoke this authorization at any time in writing and present my written revocation to the Georgia Skin Cancer facility. Unless otherwise revoked, this authorization will expire one year from the date below signed or as listed: ____ / ____ / _____.

_____ _____
Patient Name (Print) Date

_____ INTERNAL USE: MRN _____
Patient Signature