JAMES RIVER DERMATOLOGY

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient Name: ______________________________

Date of Birth: ______________________ **Last four digits of SSN:** ______________

I request a copy or summary of the following medical records:

- ☐ **Last Office Visit Notes and all Biopsy Reports**
- ☐ **Complete Medical Record**
- ☐ **Biopsy Report(s)**
- ☐ **Lab Report(s)**
- ☐ **Consultation Reports**
- ☐ **Allergy Test/Treatment**
- ☐ **Surgical**
- ☐ **Other** ______________________________

For dates of service from ______________ **to** ______________

☐ **Check box if you would like all dates of service included**

Additional Comments:

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☐ **Request to transfer records TO James River Dermatology, LLC from the office listed below**
☐ **Request to transfer records FROM James River Dermatology, LLC to the office listed below**

Name: ______________________________

Address: ______________________________

Phone: ______________________ **Fax:** ______________________

______________________________ ______________________

Patient or Legal Guardian Signature **Date**

Phone: 804-379-0116 Fax: 804-379-1088 Web: www.jamesriverderm.com