MR#:_____

DermOne™
Dermatology, Cosmetic & Scarless Vein Center

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Accredited Vascular Laboratory

RELEASE OF MEDICAL RECORDS

FROM: Patient Name: _____
Address: _____
_____
Birth Date: _____ SSN: _____

TO: DermOne Dermatology, Cosmetic & Scarless Vein Center
6752 Rock Spring Road, Suite 200
Wilmington, NC 28405

I do hereby consent and authorize you to release copies of ALL of my medical records, including current and previous medical records from other practices and practitioners, hospitals, urgent care and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consents for the release of alcohol, drug, psychiatric and psychological information and any information relating to pregnancy, sexually transmitted disease, HIV testing, AIDS and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing and cancer results. I agree that a copy of this release or a fax of this shall be as valid as this original release.

☐ **I HAVE READ AND AGREE TO THIS CONSENT FOR ALL OF MY MEDICAL RECORDS TO BE SENT TO:**

Physician's Name: _____
Address:_____
_____
Phone:_____
Fax:_____

☐ **I HAVE READ AND AGREE TO THIS CONSENT FOR ALL OF MY MEDICAL RECORDS TO BE RELEASED TO:**_____

_____
Patient's Signature/Legal Guardian's Signature, if indicated

_____
Witness

_____
Date

Records sent / received on:_____ By:_____