Shah DERMATOLOGY

Center for Advanced Aesthetics

Authorization for Release of Medical Records

Patient's Name _____ DOB (MM/DD/YYYY) _____ Today's Date _____

Patient's Address _____ City _____ State _____ Zip _____

Primary Phone Number _____

I request and authorize the release of my medical records at Shah Dermatology, LLC to the appropriate organization, agency, or individual named on this request. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it. If not revoked by me, this authorization will automatically expire in one year from today.

Please release Medical Records to:

☐ Medical Office ☐ Patient/Private Address** ☐ Non-Medical Office/Facility**

Name _____

Address _____

Phone Number _____

Fax Number _____

Email Address (if applicable) _____

Please include:

☐ All Records (including all notes, lab, and pathology reports)

☐ Clinical Notes

☐ Lab and Pathology Results

☐ Other: _____

Patient/Representative Signature _____ **Date** _____

Print Name _____ **Witness Signature** _____

** Requests for sending medical records to a private address or non-medical office/facility may be subject to fees determined by state law, contractual agreements, and/or office policies.