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PHI Release Authorization – to The Dermatology & Skin Cancer Center, PA

Patient Name: _____

Date of Birth: _____ Patient SS#: _____ Release/Request Date: _____

I, _____, hereby request and consent to the release and disclosure of my personal health information (PHI) FROM:

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

This release authorization includes my personal health information consisting of:

Entire medical record or part of my medical record , including:

Please SEND this PHI via fax to: 919/782-7929
Or mail to: The Dermatology & Skin Cancer Center, PA
4201 Lake Boone Trail, Suite 200
Raleigh, NC 27607

Patient's Signature

Date