BOONE DERMATOLOGY CLINIC
169 BIRCH STREET
BOONE, NORTH CAROLINA 28607
TELEPHONE (828) 264-4553
FAX (828) 262-3649
WWW.BOONEDERMATOLOGY.COM

Ronald J. Stanley, M.D.
Stan Whittaker, M.D.
Aaron Westphal, M.D.
Brett T. Summey, M.D.
Brittain H. Tulbert, M.D.
Michael Garner, M.D.
Carol C. Marks, PA-C
Erin G. Howard, MSPAS, PA-C
W. Gary Engstrom, MPAS, PA-C
Meera Shah, MSPAS, PA-C

Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: ____/_____/_____

Address: _____

City: _____ State: _____ Zip code: _____

Request Records From:	Send Records To:
_____ Clinic Name	_____ Clinic Name/ Patient Name
_____ Address City, State, Zip	_____ Address City, State, Zip
_____ Fax # Phone #	_____ Fax # Phone #

***** PLEASE ALLOW 48 HOURS FROM THE TIME YOUR CONSENT IS RECEIVED FOR THE RELEASE OF YOUR RECORDS*****

Information to be released

__ Complete Medical Records

__ Pathology Results Only

__ Labs

__ Other _____

Purpose of Disclosure

__ Continuing Care

__ Transferring Care

__ At My (patient) Request

__ Other _____

For Dates of Service from: _____ to _____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information, and any information relating to pregnancy, sexually transmitted diseases, 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 release shall be as valid as this original release.

_____

Signature of Patient/Guardian/Authorized Person (Print and Sign) Date

_____

Witness Date

Office Use only

Date Request Filled : BY: Mailed Faxed Picked Up In Office