<u>**Valley Dermatology Center, Inc.**</u>

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# RECORDS RELEASE

**_____ I hereby authorize my records to be received from:**

______________________________________

______________________________________

______________________________________

______________________________________

**and be released to Valley Dermatology Center.**

**____ I hereby authorize my records to be sent from Valley Dermatology Center to:**

______________________________________

______________________________________

______________________________________

______________________________________

**The records that I would like to be sent/received are:**

**_____Progress Notes**
**_____Pathology Results**
**_____Lab Results**

**PATIENT NAME: _____________________________________________ DOB: _____________**

**AUTHORIZED SIGNATURE: __________________________________ DATE: ____________**

**WITNESS: ___________________________________________________ DATE: ____________**