**Medical Records Release**

From: Riva Dermatology  
(P) 704-896-8837 | (F) 704-896-8892

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

Patient:

Date of Birth: \_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

I hereby authorize you to release **TO** Riva Dermatology, PLLC the following:

I hereby authorize you to release **FROM** Riva Dermatology, PLLC the following:

\_\_\_\_\_ Complete Medical Record  
\_\_\_\_\_ Biopsy Report(s)  
\_\_\_\_\_ Lab Report(s)  
\_\_\_\_\_ Consultation Reports  
\_\_\_\_\_ Medication Allergies  
\_\_\_\_\_ Allergy Test/Treatment  
\_\_\_\_\_ Surgical Procedures  
\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check one:

\_\_\_\_\_ For dates of service from\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ to \_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_  
\_\_\_\_\_ For all dates of service

I understand that there may be a reasonable medical records copying fee as permissible by state law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_  
Patient Signature Date