MEDICAL RECORDS RELEASE

www.susongderm.com

Authorization To Release Medical Records/Information

C.Rodney Susong, MD, PC - 2051 Hamill Road, Suite 301, Hixson TN 37343
Phone: (423) 870-3376 Fax: (423) 877-1387

Physician/facility to provide medical records: _____

Patient Name: _____ Date of Birth: _____

Phone #: _____ SSN: _____

Please Release My Records To: _____

Address: _____
Street City / State / Zip

Office Number: _____ Fax #: _____

I request a copy or summary of the following medical records: (please ☑ all that apply)

- ☐ Complete Medical Record
- ☐ Specific Office Visit(s)
- ☐ Pathology/Biopsy Report(s)
- ☐ Lab Report(s)
- ☐ PDT Results
- ☐ Laser/VBeam Report
- ☐ Other: _____

Please ☑ one:

- ☐ For dates of service from ___/___/___ to ___/___/___
- ☐ For all dates of service

I understand that I may revoke this authorization at any time and that unless an earlier date is specified, it will automatically expire 12 months from the date signed.

Patient Name (Print): _____

Person Authorized to sign for patient: _____

Patient Signature: _____

Signature/Relationship to patient: _____

Date: _____

Date: _____