

## Medical Records Release Form

By signing this form, I authorize Verum Cutis Dermatology to release confidential health information about me, by releasing a copy of my medical records, summary, or narrative of my protected health information (PHI), to the physician/person/facility/entity listed below.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Unless otherwise specified your complete records will be released. If you wish to limit what is released, please list the items that you DO NOT want sent:

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Release my PHI to the following physician/person/facility/entity and/or those directly associated with my medical care:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient/Representative Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Printed Representative Name