VERUM CUTIS DERMATOLOGY

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703-687-3105 • Fax 571-291-2338 • www.VerumCutis.com

Medical Records Request Form

By signing this form, I authorize _____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 Verum Cutis Dermatology

Patient Name: _____ DOB: _____

Unless otherwise specified please send complete records.

Items you DO NOT want released:

_____

_____

_____

Send to:

Verum Cutis Dermatology
19500 Sandridge Way, Suite 320
Leesburg, VA 20176
703-687-3105
FAX: 571-291-2338

_____ _____

Print Patient Name Patient/Representative Signature

_____ _____

Today's Date Printed Representative Name