

RECORDS TRANSFER REQUEST

PLEASE PRINT

Date _____

Patient Name _____

Social Security # _____

Date of Birth _____

This authorization is being given in compliance with the general terms of the confidentiality of medical information.

By my signature below, I authorize Van Dam Dermatology & Laser Center to release all information in my medical record to:

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

This authorization (circle one) DOES/DOES NOT apply to testing regarding HIV status.

This authorization is valid only for release one time to the person(s) listed above. I understand that I will be charged the actual cost of preparing these records for release.

Print Name of Patient

Signature of patient, parent or guardian

\$10.00 Record Transfer Fee _____