1180 Resurgence Drive.
Suite 100
Watkinsville, GA 30677

Obtaining from:
Please **mail** records
larger than 20 pages.

Main Office: (706) 543-5858 **Medical Records Fax: (706) 621-5798**

MEDICAL RECORDS REQUEST/RELEASE FORM

Patient Name: ___________________________________ Date of Birth: __________________

I HEREBY AUTHORIZE GEORGIA SKIN CANCER TO: *INITIAL BELOW*

_______ **RELEASE INFORMATION TO**:	_______ **OBTAIN INFORMATION FROM**:

____
Person or Entity or Name of Provider or Facility

____
Address/City/State/Zip

____
Phone Number Fax Number

Please *initial* specific information requested for release:

_______ Biopsy Results and Lab Reports – Specify, if needed: ________________________

_______ Dermatologic Surgical Procedures – Specify, if billing related: ________________

_______ Medications/Prescription Plans

_______ Progress/Office Notes – Specify, if applicable: ____________________________

_______ All Protected Health Information (PHI) in medical record

_______ Other: ____

For the purpose of: CHECK ONE

___ Healthcare Facility/Continuing Care
___ Legal
___ Personal
___ Disability
___ Insurance/Cancer Policy
___ Transferring Care
___ Physician
___ Other (Please specify): ___________________

I understand I may revoke this authorization at any time in writing and present my written revocation to the Georgia Skin Cancer facility. Unless otherwise revoked, this authorization will expire one year from the date below signed or as listed: ____ / ____ / _________.

____ __________________________________
Patient Name (Print) Date

INTERNAL USE: MRN _____________

____
Patient Signature

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