



1180 Resurgence Drive  
Suite 100  
Watkinsville, GA 30677

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

MEDICAL RECORDS REQUEST/RELEASE FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

_____ <b>RELEASE INFORMATION TO:</b>	_____ <b>OBTAIN INFORMATION FROM:</b>
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\_\_\_\_\_  
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: \_\_\_\_\_

\_\_\_\_\_ Dermatological Surgical Procedures – Specify, if billing related: \_\_\_\_\_

\_\_\_\_\_ Medications/Prescription Plans

\_\_\_\_\_ Progress/Office Notes – Specify, if applicable: \_\_\_\_\_

\_\_\_\_\_ All Protection Health Information (PHI) in medical record

\_\_\_\_\_ Other: \_\_\_\_\_

**For the purpose of: CHECK ONE**

\_\_\_ Healthcare Facility/Continuing Care

\_\_\_ Insurance/ Cancer Policy

\_\_\_ Legal

\_\_\_ Transferring Care

\_\_\_ Personal

\_\_\_ Physician

\_\_\_ Disability

\_\_\_ 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

\_\_\_\_\_  
Patient Signature

INTERNAL USE: MRN \_\_\_\_\_

Requested By: PROVIDER \_\_\_\_\_ / PATIENT \_\_\_\_\_