Laura Phieffer, MD — *Board Certified Dermatologist*

Shannon Chase, FNP — *Board Certified Nurse Practitioner*

Courtney Kendall, NP — *Board Certified Nurse Practitioner*

RELEASE OF MEDICAL RECORDS

Patient Name:_______________________________ Date of Birth:____________

By signing this, I authorize Avenues Dermatology to:

- ☐ obtain my protected health information (medical records) from:
- ☐ release my protected health information (medical records) to:

Office or Provider's Name:

Phone Number: Fax Number:

Information to be sent:

____Complete Medical Record	____Office Notes
____Pathology Reports	____Labwork

I understand that I am giving my permission to the above-named provider to disclose confidential health care records. I understand that I have the right to revoke this consent. The person who receives the records to which this consent pertains may not disclose them to anyone else without my separate written consent unless the recipient is a provider who makes a disclosure permitted by law.

_____________________________________ ___________________________

Signature of Patient or Legal Guardian Relationship to Patient

____

Date

420 Libbie Avenue · Richmond, Virginia 23226 Telephone: 804-288-4410 · Fax: 804-288-4458