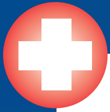

Yadkin Valley Dermatology

An Affiliate of Hugh Chatham Memorial Hospital

Authorization for Release of Medical Records

I, ____, do hereby consent and authorize

____

to release to Yadkin Valley Dermatology all medical records relating to my (or my dependent child's) identity, diagnosis, prognosis and medial care. This may include psychiatric treatment, diagnosis and/or treatment of HIV related illness, sickle cell disease, or hepatitis. I understand the extent or nature of the medial information to be disclosed includes:

____

Furthermore, I understand that this authorization is revocable by me at any time should I provide a written, signed notice of revocation to Yadkin Valley Dermatology, except to the extent that any action has already been taken on this release. Otherwise consent will remain in force for 90 days.

Special limitation or restrictions (if any): ____

____

____ ____________________________
Signature of Patient Date

____ ____________________________
Signature of Witness Date

____ ____________________________
Signature of Parent/Legal Guardian Date

(336) 835-0165 • 201-A Eldon Parks Drive • Elkin, NC 28621
www.YadkinValleyDermatology.com

Yadkin Valley Dermatology
Our Region's **CHOICE** *for* TECHNOLOGY & CARE