

Raleigh Dermatology Associates, PA

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Record Request Authorization

Records Are To Be Retrieved From: Raleigh Dermatology Associates, PA

Records Are To Be Sent To:

Name of Location: _____

Address: _____

Phone Number: _____ Fax Number: _____

Patient Information:

Patient's Name: _____ DOB: _____

Address: _____

Phone: _____

I do hereby consent and authorize you to release copies of my medical records. I understand this authorization includes consent for the release of alcohol, drug, psychiatric, and psychological information; any information relating to pregnancy, sexually transmitted diseases, HIV Testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as this original. Please send copies of all restricted information as soon as possible to the address listed.

I understand I will be charged a minimum fee of \$10.00 and a maximum of \$25.00, based on the following for faxing or photocopying and mailing my records. It may take up to 3-5 business days to process my request.

- \$ 0.75 for first 25 pages
- \$0.50 for pages 26-100
- \$0.25 for pages over 100

All Clinical Medical Records

Specific Date: From _____ To _____

Partial Records – Please list (e.g. pathology, photographs, etc.) _____

I prefer to have my records: Faxed Mailed Picked up

Note: Charts over 20 pages will not be faxed

Patient's Signature _____ Date _____

Provider Signature _____ Date _____