Dermatology Practice of the Carolinas, P.A.
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Catherine J Pointon, MD **Katherine Joseph, PA-C**

CONSENT FOR MEDICAL RECORDS RELEASE

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I request a copy of the following medical records:

__ **Complete Medical Records**

__ **Biopsy Report(s)**

__ **Lab Report(s)**

__ **Consultation Reports**

__ **Medication Allergies**

__ **Allergy Test/ Treatment**

__ **Surgical Procedures**

__ **Other_____**

LAST NAME_____ FIRST _____

STREET_____

DATE OF BIRTH_____ SSN_____

I hereby release you from all legal responsibility or liability that may arise from this authorization.

_____ _____
Patients Signature **Date**

_____ _____
Witness **Date**

There is a $20.00 processing fee to release records.