

CAROL L. PIATT, M.D.

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MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____

Patient DOB: _____

Address: _____

To: _____

I authorize you to release my medical records to the above-listed physician.

Please release any and all information including copies of medical records, copies of pathology and hematology reports and any other records of examination or treatment rendered to me during the period of _____ to _____.

Requesting Patient Signature

Witness

Date

Carol L. Piatt, M.D.
Board Certified in Dermatology & Family Practice
Fellowship in Dermatologic Oncology & Surgery