

**CAROL L. PIATT, M.D.**

10560 Main Street  
Suite 415  
Fairfax, VA 22030  
703.691.3376

**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**