Vieta
DERMATOLOGY

289 Olmsted Blvd, Suite 5, Pinehurst, NC 28374
Phone: (910) 420-1282 / Fax: (910) 420-1116

REQUEST FOR MEDICAL RECORDS TO BE SENT TO VIETA DERMATOLOGY, PLLC

Medical Record Number: (to be filled in by practice)_____

Patient Name: _____ DOB: _____
Street Address: _____ Apt#: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

I, (NAME) _____, hereby authorize _____
_____ to release the following information:

- ◯ All Records
- ◯ Discharge Summary
- ◯ Hospital Records
- ◯ Emergency Department Records
- ◯ Radiology Reports (Ultrasounds, X-rays, MRI, CT scans)
- ◯ Consultation Notes
- ◯ Office Visit Notes
- ◯ Procedure Notes
- ◯ Surgery/Operative Reports
- ◯ Pathology/Lab Reports

Dates of service for requested release:

- ◯ All Dates
- ◯ Date Range _____ to _____

RELEASE INFORMATION TO: Vieta Dermatology, PLLC
289 Olmsted Boulevard, Suite 5
Pinehurst, NC 28374
Phone: (910) 420-1282
Fax: (910) 420-1116
www.vietadermatology.com

Signature of patient or of individual authorized to act on patient's behalf:

_____

Printed Name: _____ Date: _____