STEELE CREEK
DERMATOLOGY

11040 South Tryon St
Suite 203
Charlotte, NC 28273
Phone 704-587-3200
Fax 704-587-0044

☐ **Jennifer L Helton, MD**
☐ **Rachelle Cronin, PA-C**
☐ **Linda Ryznar, PA-C**

CONSENT FOR MEDICAL RECORDS RELEASE

From: _____ To: _____
_____ _____
_____ _____
_____ _____

I request a copy of the following medical records:

____ Complete Medical Records
____ Biopsy Report(s)
____ Lab Report(s)
____ Consultation Report(s)
____ Medication Allergies
____ Allergy Test / Treatment
____ Surgical Procedures
____ Other _____

FIRST NAME_____LAST NAME_____

STREET_____

CITY_____STATE_____ZIP CODE_____

DATE OF BIRTH_____SSN_____

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

_____ _____
Patients Signature Date

_____ _____
Witness Date

There is a processing fee to release medical records.