BLUE RIDGE DERMATOLOGY ASSOCIATES, PA

Maureen L. Aarons, M.D. Carrie D. Alspaugh, M.D
Shelley Cathcart, M.D. Jayashri V. Ghate, M.D.
Kendall S. Hash, M.D. Michele L. Lokitz, M.D.
Lavanya V. Nagaraj, M.D. Katherine D. O'Rourke, M.D

AUTHORIZATION FOR REQUEST OF MEDICAL INFORMATION RELEASED TO BRDA

_____ _____
Print full Name Date of Birth

_____ _____
Street Address Home Phone

_____ _____
City, State, Zip Work Phone

I do hereby authorize _____
(Physician or Practice Name, Address and Phone Number)

to release to BRDA the following:

____ Discharge Sumary ____ Operative Notes ____ ECG/EEG/Cardiac Cath
____ History & Physical ____Pathology Reports ____ Other _____
____ Progress Notes ____Lab Reports ____ Other _____

From the time period of _____ to _____

Information Released To: Blue Ridge Dermatology Associates, P.A.
3225 Blue Ridge Road Ste 101
Raleigh, NC 27612
Fax Number: 919-510-5090

Purpose of Disclosure:

_____ Referral to Specialist _____ Insurance
_____ Legal Investigation _____ Disability Determination
_____ Personal _____ Change of Doctor

Please provide current daytime telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization.

Signature of Individual or guardian or
Personal Representative of patient's estate: _____ Date: _____