Dermatology
*of* North Asheville

*Please complete this form and fax or mail it to our practice*

## Patient Request For Medical Records Form

I, _____, request and give my permission to release my Medical Records **FROM** the following Medical Clinic:

**Dermatology of North Asheville, PA**
**209 East Chestnut Street**
**Asheville, NC 28801**
**Phone (828) 253-2533 ● Fax (828) 253-2536**

☐ All records

☐ Specified records:

_____

☐ Specified dates: _____ to _____
From To

The Medical Records as listed above are to be **released to**:

Facility Name / Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

_____ _____
Printed Patient Name Date of Birth

_____ _____
Patient's Signature Today's Date

**MARK E. HUTCHIN, M.D.**
*tel* 828.253.2533 *fax* 828.253.2536 *www.ashevillederm.com*
209 East Chestnut Street Asheville, North Carolina 28801