Carrie D. Alspaugh, M.D.
Shelley D. Cathcart, M.D.
Jayashri V. Ghate, M.D.
Nikita S. Goel, M.D.
Kendall S. Hash, M.D.
Michele L. Lokitz, M.D.
Jocelyn Mendes, M.D.
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Katherine D. O'Rourke, M.D.
Lindsay P. Osborn, M.D.
Brittany M. Atkinson, P.A.-C
Caroline C. Day, P.A.-C
Karla Flores-Chavez, P.A.-C
Holly M. Rasmussen, P.A.-C

AUTHORIZATION FOR REQUEST OF MEDICAL INFORMATION RELEASED TO BLUE RIDGE DERMATOLOGY ASSOCIATES, P.A.

________________________________ 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 Summary
____ History & Physical
____ Progress Notes
____ Operative Notes
____Pathology Reports
____Lab Reports
____ ECG/EEG/Cardiac Cath
____ Other ____________________
____ ____________________

From the time period of ____________________________ to ________________________________

Information Released To: Blue Ridge Dermatology Associates, P.A.
4225 Macon Pond Road, Ste 300
Raleigh, NC 27607
Fax Number: 919-510-5090

Purpose of Disclosure:

_____ Referral to Specialist
_____ Legal Investigation
_____ Personal
_____ Insurance
_____ Disability Determination
_____ 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 affect 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: ___________

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