Dermatology Associates
OF MONTGOMERY, LLC

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Montgomery, AL 36124-1627
334/396-1555 (office) | 334/396-9833 (FAX)

J. S Maddox, MD *E.P. Barnett, MD* *E.A. Mountcastle, MD*

Authorization for Release of Medical Records from Dermatology Associates of Montgomery

I, ______________________________ authorize Dermatology Associates of Montgomery to release the following medical information.

Please mark all that apply:

_____ any and all medical records

_____ biopsy report(s)

_____ surgery notes

Dates of service: From _____________ to ______________

Send to: (please provide address)
____
____
____

By Alabama law, we have 30 days to complete the records request. If the chart is at an off-site location, we have 60 days.

Charges for medical records are the patient's responsibility.

This release is effective for one year from the date signed; however, it may be revoked at any time by providing written notice.

Signature: ___________________________ Date: ___________________________
PATIENT/LEGAL GUARDIAN

Date of Birth: ________________________ Telephone Number: ______________

Witness: ____________________________ Date: ___________________________