ATLANTIC SHORE DERMATOLOGY

Ashley C. Cavalier, MD
Board Certified,
American Board of Dermatology
Rachel Hawkins Duncan, PA-C
Katie Lawson Hageman, PA-C

Authorization to Release Medical Information

Date: ______/______/______

To: ____

Phone: ____________________________ Fax: ____________________________

I authorize you to release to Atlantic Shore Dermatology:

☐ 7000 Wellness Way, Suite 7120
St Simons Island, GA 31522
Phone 912-634-4966
Fax 912-634-6542

☐ 400 Lister Street
Waycross, GA 31501
Phone 912-283-4850
Fax 912-283-4864

Any information including diagnosis and records of any treatment or examination rendered to me.

Patient's Name: ____

Daytime Phone: ____________________________

Date of Birth: ______/______/______

Reason for request: ____

_____________________________ Patient Signature

_____________________________ Witness