DERM ONE
Dermatology Care

Patient Information Release Form

Patient Name: _____

I authorize the person(s) listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case.

I have the right to terminate this agreement at any time by informing the staff in writing.

Authorized Person(s)	Relationship to Patient

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

BLUEFIELD, VA
276-326-DERM (3376)
725 S. College Ave.
Bluefield, VA
24605

RADFORD, VA
540-633-3015
1804b E. Main Street
Radford, VA
24141

WYTHEVILLE, VA
276-228-2022
150 Peppers Ferry Rd.
Wytheville, VA
24382

BECKLEY, WV
304-255-9434
250 George Street
Beckley, WV
25801

PRINCETON, WV
304-425-9448
206 New Hope Road Suite 1
Princeton, WV
24740