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DERMATOLOGY

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: _____

_____

_____

I hereby authorize and request you to release the following information:

( ) All records ( ) Laboratory/pathology records

( ) X-ray/radiology records ( ) Summary/office notes

( ) Pharmacy/prescription records ( ) Other (specify) _____

_____

Please fax or mail records to:

_____

_____

_____

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____/_____/_____

Signature: _____ Date: _____/_____/_____