

Medical Records Release Form

I, _____, herein request of
Print Patient Name

_____ Phone #: ____ - ____ - ____ Fax #: ____ - ____ - ____
Doctor With Records

Address: _____
Street Zip City State

To forward a copy or summary of the following medical records:

_____ Complete Medical Record

_____ Biopsy reports

_____ Lab reports

_____ Consultation Reports

_____ Allergy Test/ Treatment

_____ Surgical Procedures

_____ Specify: _____

For dates of service from ____/____/____ to ____/____/____.

To:

Dermatology Specialists of Charlotte

8936 Blakeney Professional Drive
Charlotte, NC 28277
Phone #: 704-943-3714
Fax #: 866-212-0355

Date Needed ____/____/____

Signature: _____ Date: ____/____/____

Relationship to the patient: _____

Witness: _____ Date: ____/____/____