Records Release Authorization

Patient Name_____ Date of Birth_____

Address_____

Phone Number_____

RECORDS REQUESTED FOR DERMATOLOGY PARTNERS

Name of Provider or Office_____

Practice Address_____

Phone Number _____ Fax Number_____

RECORDS TO RELEASE TO

Name of Provider or Office_____

Practice Address_____

Phone Number _____ Fax Number_____

Please select all the specific documents that apply to your request:

- (●) Office notes
- ( ) Prescription/Medications
- (●) Treatment Plans
- ( ) Billing records, statements, insurance claims
- ( ) Laboratory records and Specimens

Signature of Patient/Guardian_____Date_____

Printed Name of Patient_____

Date sent/received by Dermatology Partners team member_____

Initials_____

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