Dermatology & Skin Cancer Surgery Center
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MEDICAL RECORDS RELEASE

I request a copy of my medical records be released to:

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From the office of: ____

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I request a copy of the following medical records:

- o Complete Medical Records
- o Biopsy Report(s)
- o Lab Report(s)
- o Consultation Report(s)
- o Medication Allergies
- o Allergy Test / Treatment
- o Surgical Procedures
- o Other ______________________________

o For dates of service from _______________ to _______________

__________________________________	______________
Patient Name	Date of Birth
__________________________________	______________
Signature of Patient, Parent or Guardian	Date