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MEDICAL RECORDS RELEASE

TO: _____

PHONE:_____ FAX:_____

*I,*_____*, herein request of*
Print Patient's Name

_____
Doctor of Facility Holding Records

_____
Address City State Zip code

PLEASE FORWARD A COPY OR SUMMARY OF THE FOLLOWING MEDICAL RECORDS TO OUR OFFICE AT 888-331-1448. IF YOU HAVE DIRECT MAIL CAPABILITY, PLEASE SEND RECORDS TO:

bueller@brderm.emadirect.md

_____Pathology Reports

_____Medication List

_____Complete Medical Record

_____Lab Reports

_____
Patient Signature Date

_____
Witness Date