PLANT CITY DERMATOLOGY, PA

REQUEST FOR RELEASE OF MEDICAL RECORDS

____
Physician

____
Address

____
City State Zip code

Telephone: ______________________________

Fax: ____________________________________

I, ______________________________________, DOB_______________ hereby request that a

copy of: ____Complete Medical Records ; ____Biopsy Report(s); ____Lab Report(s);

be released to PLANT CITY DERMATOLOGY

PLANT CITY DERMATOLOGY
1501 S. ALEXANDER ST, SUITE 103
PLANT CITY, FLORIDA 33563
Telephone: 813-498-1933
Fax: 813-662-3009

____ __________________
Patient DOB Date

____ ___________________
Parent/Guardian Date

____ ____________________
Witness Date