PLANT CITY DERMATOLOGY

P: 813-498-1933~F: 813-662-3009

REQUEST FOR RELEASE OF MEDICAL RECORDS

I, _____, DOB_____

request that a copy of:

____Complete Medical Records; ____Biopsy Report(s); ____Lab Report(s) be released to:

_____
Name

_____
Address

_____
City State Zip code

Fax: _____

_____ _____
Patient DOB Date

_____ _____
Parent/Guardian Date

_____ _____
Witness Date

1501 S ALEXANDER ST, SUITE 103
PLANT CITY, FL 33563
www.plantcitydermatology.com