Dermatology Professionals · Inc

1672 South County Trail, Suite 101 & 301, East Greenwich, RI 02818
Phone 401.885.7546 Fax 401.885.6640

MEDICAL RECORD RELEASE / RELEASE AUTHORIZATION

Please print clearly

Patient Name_____Date of Birth_____

Address_____

_____

Phone ( ) _____ - _____

_____I hereby authorize Dermatology Professionals, Inc to send my record **to:**

_____I hereby authorize Dermatology Professionals, Inc to request my record **from:**

_____

_____

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_____

Information to be disclosed (please check)

- ☐ Complete Medical Records
- ☐ Skin Biopsy Reports
- ☐ Lab Reports
- ☐ Surgical Procedures
- ☐ Other_____

Purpose (at request of patient, legal, moving, changing provider, etc.)

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I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

Signature_____Date_____
patient/parent or legal guardian

Allow 5-10 days for the Record to be copied and sent

Rev 04-2018