Medical Records Release Form For General Dermatology Patients

Phone number: 731-784-4300
Fax: 731-241-0009

To: _____ Request Date: _____

_____

_____

I hereby authorize you to release medical records of:

Patient Name:_____

Date of Birth:_____

Please mail medical records to:

Dermatology and Skin Cancer Consultants, PLLC
701 Medical Park Drive Humboldt, TN 38343

Or fax to: 731-241-0009

Information Needed:

_____Pathology Reports

_____Dermatology Chart Notes from 8/1/08 to present

Please call 731-784-4308 if you have any questions. We appreciate your assistance.

This authorization maybe revoked at any time. Unless revoked earlier. This consent will expire 180 days from the date of signature or shall remain in effect for the period needed to complete the request.

_____ _____

Signature of Patient Date