**Medical Records Request Form**

# The Dermatology Center, P.C.

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**RECORDS RELEASE**

**RECORDS REQUEST**

To:_____
_____
_____
_____
Phone:_____
Fax:_____

Patient:_____
DOB:_____
SS#:_____

Information requested:
Complete Medical record_____
Pathology reports (dermatology only)_____
Laboratory reports_____
Other_____

Patient
Signature_____

Date_____