MEDICAL RECORDS RELEASE

Date _____

Name _____
Last Name First Name MI

Address_____

City _____ State _____ Zip _____

DOB ____/_____/_____

I, the undersigned, authorize the following:

____ The release of my medical records from _____
to Maragh Dermatology

____ The release of my Maragh Dermatology medical records to_____
Address: _____ Phone # _____ Fax # _____

____ The release of my Maragh Dermatology medical records to myself (A medical records fee may apply)

PATIENT SIGNATURE _____ DATE ____/____/____
PARENT OR GUARDIN (IF PATIENT IS UNDER 18 YEARS OF AGE)

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