Armstrong Dermatology and Skin Cancer Center P.A.
9170 Oakhurst Road, Suite One
Seminole, FL 33776
(727) 517-DERM (3376)

REQUEST FOR RECORDS RELEASE

Physician's Name: ____

Street Address: ____

City: ____________________________________ State: ______________ ZIP Code: _______

Dear Doctor: __________________________:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name: ____

Birthdate: ______________________________ Social Security Number: __________________

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please be sure to include pathology and surgery reports.

Thank you for expediting this request. Please send these records to our office address shown above.

I hereby authorize the release of all necessary medical records to _____________________. I wish for them to be forwarded as soon as possible.

Patient's Signature: _______________________________________ Date: ________________
(or parent if patient is a minor)

Patient's Address: ______________________ City: ___________ State: ____ ZIP: ______