BRANDON DERMATOLOGY, PA

REQUEST FOR RELEASE OF MEDICAL RECORDS

____
Physician

____
Address

____
City State Zip code

Telephone: ______________________________

Fax: ___________________________________

I, ____________________________________, DOB______________ hereby request that a

copy of: ____Complete Medical Records ; ____Biopsy Report(s); ____Lab Report(s);

be released to BRANDON DERMATOLOGY, PA

BRANDON DERMATOLOGY, P.A.
405 W BLOOMINGDALE AVE
BRANDON, FLORIDA 33511
Telephone: 813-662-3376
Fax: 813-662-3009

______________________________________ ________________
Patient DOB Date

______________________________________ ________________
Parent/Guardian Date

______________________________________ ________________
Witness Date

www.brandondermatology.com