Yardley Dermatology Associates

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MEDICAL RECORDS RELEASE

Patient Name: please print _____

Date of Birth: _____

Address: _____

To Yardley Dermatology Associates,

I hereby authorize the release of my medical records for the purpose of medical management to:

_____
Doctor, Hospital, Insurance Company, etc.

Address: _____

_____

Phone: _____

Fax: _____

Please send the following:

☐ Recent Biopsy or Bloodwork ☐ All

☐ Other _____

_____ _____
Signature of Patient or Legal Guardian *Date*