DERMATOLOGY PROFESSIONALS, INC.
1672 South County Trail, Suite 101 & 301
East Greenwich, RI 02818
Phone: (401) 885-7546
Fax: (401) 885-6640

MEDICAL RECORD RELEASE/RELEASE AUTHORIZATION

Patient's Name ____

Date of Birth _____/_____/_____

Address ____

____

____

Telephone Number (_____) ______-________

______I hereby authorize Dermatology Professionals, Inc. to send my record to:

______I hereby authorize Dermatology Professionals, Inc. to request my record from:

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Please release all records, including but not limited to, office-visit notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

Signature ________________________________ Date ___________________________
(Patient/Parent or Legal Guardian)

NOTE: ALLOW 5-10 DAYS FOR RECORD TO BE COPIED AND SENT