

Dermatology Professionals LLC

153 East Washington Street
North Attleboro, MA 02760

Phone: (508) 699-7546 Fax: (508) 699-7570 (Gen Derm)
Phone (508) 699-6647 Fax: (508) 699-6630 (Mohs)

MEDICAL RECORD RELEASE/RELEASE AUTHORIZATION

Patient's Name _____

Date of Birth ____/____/____

Address _____

Telephone Number (____) _____ - _____

_____ I hereby authorize Dermatology Professionals LLC to send my record to:

_____ I hereby authorize Dermatology Professionals LLC to request my record from:

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

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