RAJAN DERMATOLOGY

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MEDICAL RECORDS RELEASE

(Please fill out all lines-even if the information is the same)

PLEASE RELEASE MY RECORDS FROM:	
Doctor / Company:	
Address:	
Phone:	Fax:

PLEASE RELEASE MY RECORDS TO:	
Doctor / Company:	
Address:	
Phone:	Fax:

PATIENT INFORMATION	
Patient's Name:	Patient's Date of Birth:
Patient's Address:	
Patient's Phone:	

PATIENT SIGNATURE

This authorization will expire one year from the date below unless otherwise stated in writing.

Signature of patient or guardian _____ Date _____