INTEGRATED DERMATOLOGY GROUP

Date: _____

I hereby request the release of my medical records or copies of such and request that they be transferred/released from:

Doctor/Office: _____

Address: _____

City: _____ State _____ Zip Code _____

To:

Doctor/Office: _____

Address: _____

City: _____ State _____ Zip Code _____

For the purpose of continuum of care.

_____ ***DOB***_____

Print Name of Patient

_____

Signature of Patient or Parent/Guardian

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