ROCKWALL DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC

(Print Your Name) (Today's Date)

(Your Street Address)

(Your City, State ZIP Code)

FROM

(Name of Doctor or Group who has your records)

(Phone Number)

(Fax Number)

RE: Release of medical records for:

(Print Your Name) (Date of Birth) (Social Security Number)

Dear Provider:

Please release my medical records related to dermatological treatment rendered by you or under your supervision. This information will be used to further assist in my medical care.

This is: ☐ A one-time disclosure ☐ A continuing disclosure for 12 months

SEND TO

(Name of Doctor or Group to send records)

(Phone Number)

(Fax Number)

I can revoke this authorization in writing at any time. I hereby release you from any legal liability for disclosures that may arise as a result of the release of my medical records.

Sincerely,

(Sign Your Name)

(Print Your Name)