DERMATOLOGY INC. OF VIRGINIA BEACH

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MEDICAL RELEASE FORM

Patient's Name: _____

Social Security Number: _____

Date of Birth: _____

Today's Date: _____

TO SEND RECORDS:

I authorize Dr. Harr/Dr. Pike/Dr. Beck to send my medical records, treatment and findings to:

_____

_____

_____

TO RECEIVE RECORDS:

I authorize _____

_____

_____

To send my medical records, treatment and findings to:
DERMATOLOGY INC OF VIRGINIA BEACH
1200 FIRST COLONIAL ROAD, SUITE 200
VIRGINIA BEACH, VA 23454

PATIENT SIGNATURE: _____

MEDICAL RELEASE SENT: _____

BY WHOM: _____