Skin Cancer Center of Central Florida

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# RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____

Patient's Address: _____

Date of Birth: _____

To whom it may concern:

I hereby authorize _____ to release any

Medical records to Skin Cancer Center of Central Florida 352-873-9397 including

- Pathology Reports
- All Medical Records on File (will receive a disk)
- Dates of service _____
- Other Specific Information _____

  _____

For the purpose of _____.

Unless otherwise specified this authorization will expire 90 days from the date signed. Please call us if there are any problems in complying with this request.

_____ _____
Patient's Signature or responsible party Date

_____ _____
Witness Date