West County DERMATOLOGY

SKIN: Health, Safety, Beauty.

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To Whom It May Concern:

I authorize the release of my medical record TO/FROM the office of West County Dermatology.

FROM/TO:

Dr. _____

Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____Fax #: _____

Patient's Legal Name: _____

Patient's Date of Birth: _____

Patient's SS#: _____ Date(s) of Service: _____ to _____

Signature: _____ Date: _____

Witness: _____ Date: _____