SOUTH TEXAS DERMATOLOGY, PLLC

GENERAL DERMATOLOGY • COSMETIC DERMATOLOGY • MOHS MICROGRAPHIC SURGERY • SKIN CANCER SURGERY

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FAMILY NURSE PRACTITIONER

Request to Release Medical Records

______________________________, request that ______________________________________
Patient's Name (See Note) Physician's Name

Release the following medical records on the above mentioned patient to :

____
Name of receiving party

____
Address (if copies to be mailed)

____
City, State (if copies to be mailed)

____ Lab ____ Pathology ____ Progress Notes _____ All Records

Approximate date of report if applicable: ______________________________

Reason for Request: ____

____

☐ I would like the medical records mailed to the address listed above

☐ I would like the medical records faxed to ( ) ___________________

☐ I will pickup or take the medical records with me

_____________________________________ ___________________________
Signature Date

Note: The parent or legal guardian must request the Records of any patient that is under 18 years of age

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