THE DERMATOLOGY CENTER
ROCKLEDGEMEDSPA
www.dermskin.com
email: info@dermskin.com

RECORDS RELEASE FORM

From The Dermatology Center to Patient or Outside Physician

Reason for Release: _____

Patient's Name: _____ ADS#_____

Patient's Address: _____

Patient's Date of Birth: _____ Telephone #_____

I request that my medical records be released to:

(Check one): _____**Doctor** _____**Self**.

If records are to be released to a doctor please complete the name, address, and telephone number below.

Doctor's Name: _____

Telephone #: _____

Doctor's Address: _____

For the following date(s) of service: _____

Patient's/Parent's/Guardian's Signature: _____Date:_____

Relationship (if not patient): _____

Witness: _____ Date: _____

Dermatology Center Physician's approval: _____Date: _____

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Bethesda, MD 20817
Tel: 301-530-8300
Fax: 301-530-4638
Rockledge Med Spa 301-968-1200

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Germantown, Maryland 20874
Tel: 301-444-0153
Fax: 301-444-0158

5215 Loughboro Road NW, Suite 140
Washington DC 20016
Tel: 202-244-4550
Fax: 202-244-3198