

**BRANDON DERMATOLOGY, PA**

P: 813-662-3376 ~ F: 813-662-3009

**REQUEST FOR RELEASE OF MEDICAL RECORDS**

I, \_\_\_\_\_, DOB \_\_\_\_\_

request that a copy of:

\_\_\_\_ Complete Medical Records; \_\_\_\_ Biopsy Report(s); \_\_\_\_ Lab Report(s) be released to:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip code

Fax: \_\_\_\_\_

\_\_\_\_\_  
Patient DOB Date

\_\_\_\_\_  
Parent/Guardian Date

\_\_\_\_\_  
Witness Date

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