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MEDICAL RECORDS RELEASE

Patient's Name _____

Address _____

Date of Birth _____

Social Security Number _____

I herby authorize **Dr.** _____ who has attended me or examined me, to release to **Pennsylvania Dermatology Group, P.C.**, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records including biopsy reports. A photo-static copy of this authorization shall be considered as effective and valid as the original.

Signature of Patient (or Responsible Party) _____

Relationship to the Patient _____

Witness to the Above Signature _____

Date _____