cole | dermatology

Medical & Surgical Dermatology

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Medical Records Release Authorization Form

I, _____, authorize John Cole, MD and Cole Dermatology, LLC to

____ Release my records to ____ Obtain my records from

_____
_____
_____
_____

____ Complete Medical Record
____ Pathology Report(s)
____ Lab Report(s)
____ Office Note(s)
____ Surgical Procedure(s)
____ Other _____

For the dates of service from _____ to _____.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Today's Date