Compassion DERMATOLOGY

3065 W. Southlake Blvd., Suite 140
Southlake, TX 76092
Phone: 817.380.5911 / Fax: 817.385.6579
Website: compassiondermatology.com

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Phone: _____

Date of Birth: _____

I request a copy or summary of the following medical records:

- ☐ Last Office Visit Notes and all Biopsy Reports
- ☐ Complete Medical Record
- ☐ Biopsy Report(s)
- ☐ Lab Report(s)
- ☐ Consultation Reports
- ☐ Allergy Test/Treatment
- ☐ Surgical Procedures
- ☐ Other _____

For dates of service from _____ to _____

Additional Comments: _____

_____

- ☐ Request to transfer records TO Compassion Dermatology
- ☐ Request to transfer records FROM Compassion Dermatology

Office Name: _____

Address: _____

_____

Phone: _____

Fax: _____

_____ _____
Patient or Legal Guardian Signature Date

_____ _____
Witness Date