PCD Pennsylvania Centre for Dermatology, LLC

FAX AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To:	From:
Fax:	Pages:
Phone:	Date:
Re:	CC:

Patient name:_____

Date of Birth:_____

Please forward the following medical records concerning the above-named patient to our attention at your earliest convenience. Consent for the release of this information is attached.

- ☐ Complete medical record
- ☐ Pathology records
- ☐ Medical summary only
- ☐ Other:_____

I, **_____, authorize the release of medical records, as listed above, to the Pennsylvania Centre for Dermatology, 801 Spruce Street, 10th Floor Spruce Building, Philadelphia, PA 19107 (Fax 215-829-7054).**

_____

Patient's Signature Patient's Name (please print) Date

801 Spruce Street, 10th Floor
Philadelphia, PA 19107
215-829-7838 • Fax: 215-829-7054