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, 822 Pine Street, Suite 2A, Philadelphia, PA 19107 (Fax 267-519-0597)**

_____

Authorized Signature Name (please print) Date

822 Pine Street, Suite 2A
Philadelphia, PA 19107
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