Roberts Dermatology Center, P.C.
Frederick Roberts, D.O.

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MEDICAL RECORDS RELEASE

I, _____ DOB _____

hereby authorize Roberts Dermatology to disclose my medical records to: (please provide name and address below)

_____

_____

_____

I am requesting a copy or summary of the following medical records:

- ❑ Complete Medical Record
- ❑ Biopsy Report(s)
- ❑ Lab Report(s)
- ❑ Consultation Reports
- ❑ Medication list

Please check one:

- ❑ For dates of service from ____/____/____ to ____/____/____
- ❑ For all dates of service

Additional Comments: _____
_____
_____

I understand that there may be a reasonable medical records copying fee as permissible by state law.

_____ ____/____/____
Patient Signature Date