Warren Dermatology and MOHS Surgery, LLC

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Patient Records Release Authorization

Date:	
RELEASE RECORDS FROM:	(Doctor/Provider)
RELEASE RECORDS TO:	(Doctor/Provider)
PATIENT INFORMATION: Name:	
Date of Birth:	
Address:	
Phone Number:	
Reason for requesting records:	
I authorize the release of any and all requested informa	ition including the diagnosis and records for any
treatment or examination rendered.	- ,

Signature: On file

Please fax records to (330) 474-3981.