ATLANTIC SHORE DERMATOLOGY

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Authorization to Release Medical Information

Date: _____/_____/_____

I authorize Atlantic Shore Dermatology to release to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Any information including diagnosis and records of any treatment or examination rendered to me.

Patient's Name: _____

Daytime Phone: _____

Date of Birth: _____/_____/_____

Reason for request: _____

_____ _____

Patient Signature Witness