AUTHORIZATION TO RECEIVE MEDICAL RECORD

I authorize and request:

Doctor's Name or Office Name: _____

Address: _____

_____

_____

Phone: _____ Fax: _____

To furnish to Dr. C. Paulina Vu at Friendswood Dermatology all information concerning my case history and the treatment, examination, or hospitalization which I received, including copies of medical records, pathology reports, surgical records, or hospital records and reason:

__ Further evaluation and treatment

__ Continuity of care

__ At the request of the individual

_____ _____

Signature of Patient Date

_____ _____ _____

Print Patient's Name SSN DOB

_____ _____

Witness's Signature Date

Friendswood Dermatology Cosmetic & Skin Cancer Center
6 Oaktree Street, Friendswood, TX 77546
(281) 4 8 2 – DERM (3376)
(281) 947-8161 FAX