John K. Wildemore MD, LLC
Dermatology & Dermatologic Surgery

Authorization To Release Medical Records

Last Name_____ First_____ MI_____

D.O.B._____ Phone number_____

Email_____

I hereby authorize (Physician/Practice Name) _____
to release my medical records to:

Name_____

Mailing Address_____

City_____ State_____ Zip Code_____

Phone Number_____ Fax_____

Please specify what information you would like released (Entire medical record, Biopsy/Lab Reports Only, Specific Date Range):

_____

_____

I understand that by signing this form I am requesting my health information be sent to a third party and that this information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

Patient Signature _____

Date_____

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