ONSPOT DERMATOLOGY

**REQUEST FOR MEDICAL RECORDS**

Name:_____ DOB:_____
Ph:_____
Address:_____

**From:** Facility Name:_____
Facility Phone #:_____
Facility Fax#:_____
Facility Address:_____

**To:** Onspot Dermatology
1131 South Orange Ave Orlando, FL 32806
Phone: 941-444-0011
Fax: (603) 242-1653

Please release the following to the facility above (check all that apply):

- ☐ Office Visit Notes
- ☐ Pathology Reports
- ☐ Lab Results
- ☐ Imaging Reports
- ☐ Medication History
- ☐ Entire Medical Record
- ☐ Other:

_____
_____
_____

Date Range Requested:
From: _____ To: _____

By signing below, I confirm that I am the patient (or authorized representative) and consent to the release of my medical records as stated above.

Patient or authorized individual signature:_____
Date:_____