ONSPOT DERMATOLOGY

REQUEST TO RELEASE MEDICAL RECORDS

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

To: Facility Name:_____
Facility Phone #:_____
Facility Fax#:_____
Facility Address:_____

From: 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:_____