BETTY RAJAN, MD, PLLC
dermatology & skin care

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MEDICAL RECORDS RELEASE

(Please fill out all lines-even if the information is the same)

PLEASE RELEASE MY RECORDS FROM:

Doctor / Company:

Address:

Phone:

Fax:

PLEASE RELEASE MY RECORDS TO:

Doctor / Company:

Address:

Phone:

Fax:

PATIENT INFORMATION

Patient's Name:

Patient's Address:

Patient's Phone:

Patient's Date of Birth:

SIGNATURE

This authorization will expire one year from the date below unless otherwise stated in writing.

Signature of patient or guardian

Date