BERNARDO DERMATOLOGY MEDICAL GROUP

MEDICAL RECORDS RELEASE

I authorize (doctor name)_____

Address:_____

_____

Phone Number: (___)_____Fax Number: (___)_____

to release a copy of my medical records from (date)_____to_____

pertaining to the following condition:_____ to:

Doctor:_____

Address:_____

_____

Phone Number: (___)_____ Fax Number:(___)_____

I authorize use of this form from (today's date)_____ to _____

Patient's Name:_____

Address:_____

_____

Daytime Phone Number: (___)_____ Birth date_____

Patient's Signature_____ Date_____

If patient is unable to sign or is a minor:
Patient Representative Signature_____ Date_____

For office use only:
Date records were requested/sent_____Employee's Signature_____

Rev. 6/19/03 R

15525 Pomerado Road, Suite A-2, Poway, CA 92064 (858) 451-3311 FAX: (858) 451-1142