Premier Dermatologic Surgery, P.A. • Elizabeth A. Spenceri, M.D.

Medical Records Release

Patient Name: ______________________________________ DOB: __________________

Address: ______________________________________

____

Phone #: ______________________________________

Release to: ☐ Self
☐ Doctor/Health Care Provider (Please include address, phone#, fax)

Name: ______________________________________

Address: ______________________________________

____

Phone #: ______________________________________

I hereby authorize the release of my medical records as follows:

____ Complete Medical Record
____ Biopsy Report(s)
____ Lab Report(s)
____ Consultation Report(s)
____ Allergies
____ Surgical Procedures
____ Other ____

For Date(s) of service from ________________ to ________________

Additional comments:

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____ ____________________
Patient Signature Date

____ ____________________
Witness Date

Fee (if applicable): $________

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