1601 Clint Moore Road, Suite 145, Boca Raton, Florida, 33487
P (561) 210-7310, F (561) 210-7250

RECORDS RELEASE AUTHORIZATION

To: _____
(Doctor or Hospital)

Doctor or Facility Address:

_____

Doctor or Facility Phone Number:

_____

Doctor or Facility Fax Number:

_____

I, _____(Patient Name), hereby authorize and request you
to release to:

Frieder Dermatology
Attn: Medical Records
1601 Clint Moore Rd, Ste 145, Boca Raton, FL 33487

Fax #: (561) 210-7250

Please check all that apply:

_____ **Records Dates**: _____ to _____
_____ **Pathology Dates**: _____ to _____
_____ **MOH's Reports Dates**: _____ to _____
_____**Blood Work Dates**: _____ to _____

Patient's Name: _____

Date of Birth:
_____

Patient’s Signature:
_____

Date: _____