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RECORDS RELEASE FORM
From Elsewhere to the Dermatology Center

Transfer Records From:

Doctor's Name: _____

Doctor's Address: _____

Re: Patient's Name: _____ Date of Birth: _____

Please release my medical records for the date(s) of service from ___/___/___ to ___/___/___
to the Dermatology & Clinical Skin Care Center (circle the appropriate office).

6410 Rockledge Drive, Suite 201 OR 19735 Germantown Road, Suite 210
Bethesda, MD 20817 Germantown, MD 20874
Phone: (301) 530-8300 Phone: (301) 444-0153
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Signed: _____ Date: _____

Relationship (if not patient): _____

Witness: _____ Date: _____

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