Roberta F. Palestine, MD, PA
Alison Ehrlich, MD
Joseph I. Lee, MD
Iris Kedar Rubin, MD
Geeta M. Shah, MD
Thomas C. Yu, MD
Khalique S. Zahir, MD
Jennifer I. Whitman, PA-C
Amy Gawler, PA-C

RECORDS RELEASE FORM

From the Dermatology Center to Patient or Outside Physician

Patient's Name: ____

Patient's Address: ____

Patient's Date of Birth: ____________________ Telephone #__________________

I request that my medical records be released to:

(Check one): _____**Doctor** _____**Self**.

If records are to be released to a doctor please complete the name, address, and telephone number below.

Doctor's Name: ___________________________
Telephone #: _____________________________

Doctor's Address: ____

For the following date(s) of service: ____

Patient's/Parent's/Guardian's Signature: _______________________Date:__________

Relationship (if not patient): __________________________

Witness: _______________________________________ Date: _____________

Reason for Release: ____

Dermatology Center Physician's approval: ________________________Date: _______

Revised 01/12/10

6410 Rockledge Drive, Suite 201 & 205, Bethesda, MD 20817 / Tel: 301-530-8300 / Fax: 301-530-4638 / Rockledge Med Spa 301-968-1200
19735 Germantown Road, Suite 210 / Germantown, MD 20874 / Tel: 301-444-0153 / Fax: 301-444-0158
www.dermskin.com / email: info@dermskin.com