MEDICAL RECORDS RELEASE TO:
GREENSBORO DERMATOLOGY ASSOCIATES, P.A.

All information must be filled out

DATE _____

PATIENT _____
SOCIAL SECURITY NUMBER _____
DATE OF BIRTH _____
ADDRESS _____
CITY _____ **STATE** _____
ZIP CODE _____ **PHONE NUMBER** _____
PATIENT or GUARDIAN SIGNATURE _____
IF GUARDIAN _____
(Guardian's Social Security Number)
FROM DR _____

I HERBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:
(CIRCLE PYSICIAN REQUESTING RECORDS)

DR. LAURA L. LOMAX
DR. DANIEL B. JONES
DR. DREW A. JONES
DR. AMY Y. JORDAN
DR. ROBERT G. GOODRICH
DR. SUSAN E. STINEHELFER
DR. WALTER R. WHITWORTH

(OFFICE USE ONLY)

ACCOUNT# _____ PHYSICIAN'S SIGANTURE _____

2704 St. Jude Street • Greensboro, N.C. 27405-3670 • P.O. Box 14962 • Greensboro, N.C. 27415-4962
Telephone: (336) 954-7546 • Medical Records Fax: (336)-954-9898 • Clinical Fax: (336) 235-4018