RELEASE TO

GREENSBORO DERMATOLOGY ASSOCIATES, P.A.

REQUEST FOR RELEASE OF MEDICAL RECORDS
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 PHYSICIAN 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

2704 ST JUDE STREET
GREENSBORO, NC 27405

PHONE: 336-954-7546 • FAX: 336-954-9898

(OFFICE USE ONLY)

ACCOUNT# _______________ PHYSICIAN'S SIGANTURE ______________________________________