Dermatology Specialists of Kansas City, P.C

Diseases and Surgery of the Skin

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I, ____ authorize

Physician/Practice name:_____________________________________

Address: ____

City: ___________________ State: ___________ Zip: ______________

Phone: (_____)________________ Fax: (_____) ____________________

TO RELEASE TO : *(Physician)* ________________________________

Address: ____

City: _____________________ State: ______________ Zip: _________

Phone number: (___)_____________ Fax number: (_____)___________

the Medical Records of: _____________________________________

Date of Birth: ______________ **S.S.#** *(Optional)* ________________

- ☐ Full record(s) held by this office
- ☐ Record(s) for the period of ______________ through ________________
- ☐ Specific portion/section of record as follows:

Labs/Path
Demographic info
Billing Records
Other: ______________________

Signature: _________________________ **Date:** ____________