Majors Dermatology

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RECORDS RELEASE

I hereby authorize: _____
Street Address: _____
Phone: _____ Fax: _____

To release the records of: _____
Date of Birth: _____ SS#: _____

To: _____
Street Address: 753 South Washington, Fredericksburg, TX 78624
Phone: 830-992-3396 Fax: 830-992-3538

This disclosure of records authorized herein is required for the following:

_____

and such disclosure shall be limited to the following information: _____

_____

This consent is subject to revocation by the undersigned at any time except to the extent that the disclosure is already been made.

_____ _____
patient's or guardian's signature *date*

_____ _____
witness signature *date*