Integrated Dermatology of Reno

Date:_____

I hereby request the release of my medical records or copies of such and request that they be transferred/ released from:

Doctor/ Office: _____

Address: _____

City: _____ State _____ Zip Code_____

To:

Doctor/ Office: _____

Address: _____

City: _____ State _____ Zip Code_____

for the purpose of continuum of care.

_____ ***DOB*** _____

Print Name of Patient

_____

Signature of Patient or Parent/ Guardian

500 Damonte Ranch Pkwy. • Suite 1056 • Reno, NV • 89509
(775) 829-1212 • (775) 829-1179 Fax