Date: _____

I hereby authorize the release of my medical records from:

The Skin Cancer and Dermatology Institute
640 W. Moana Lane
Reno, NV 89509
Phone: 775-324-0699 Fax: 775-323-6814

Please include the following:

- ☐ Visit Notes
- ☐ Laboratory Work, Including Pathology Reports
- ☐ History
- ☐ Billing Information
- ☐ Other: _____
- ☐ Date Range: _____

Please transfer copies of the records to:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____
Thank you

_____
Printed name of patient

_____
Patient/Responsible Party Signature

_____
Patients date of birth