**CRANE STREET DERMATOLOGY**
**1225 Crane Street, Suite 102 · Menlo Park, CA 94025**

# MEDICAL RECORDS RELEASE FORM

Date of Request:____/____/____

Name of Patient: _____ DOB: ____/____/____

Patient Address: _____
Street Address

_____
City State Zip Code

I request a copy of or summary of the following medical records:

( ) Complete Medical Record
( ) Biopsy Report (s) Dated:_____
( ) Lab Report (s) Dated:_____
( ) Surgical Procedure (s) Dated:_____
( ) Consultation Report (s)
( ) Medications Allergies
( ) Allergy Test/Treatment
( ) Other_____

[ ] Please receive my records from: [ ] Please send my records to:

Physician or Institution: _____

Address: _____

Phone Number · Email · Fax:_____

_____
**Print Name (Patient or Legal Guardian)**

X_____
**Signature (Patient or Legal Guardian)**

**PLEASE ALLOW 5-10 WORKING DAYS TO PROCESS REQUEST**
**The authorization will expire one year from the date of request.**

**Info@CraneStreetDermatology.com**
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