Medical Records Release Form

I, [Print Name] _____, DOB: _____; request that my medical records be released from:

Coast Dermatology & Skin Cancer Center
J. Gregory Neily, DO / Amy Murphy, PA-C
21550 Angela Lane
Venice, FL 34293
(941) 493-7400 Phone
(941) 493-1940 Fax

Please release the following records:

- ⬭ Biopsy Report(s)
- ⬭ Progress Notes
- ⬭ Surgical Procedure(s)
- ⬭ Other
- ⬭ Initial Evaluation
- ⬭ Lab Report(s)

Please check one:

- ⬭ For dates of service from _____ to _____
- ⬭ All dates of service

⬭ Mail ⬭ Fax ⬭ Pick-up

Please be advised that Medical Records cannot be sent via e-mail

Please send my records to:

_____
Name

_____
Address

_____
City State Zip Code

_____
Phone # Fax #

_____
Patient Signature DATE