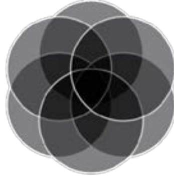

STUTZ DERMATOLOGY

919 W. UNIVERSITY DR., SUITE 100, ROCHESTER MI 48307
PHONE: 248.651.9500 FAX: 248.651.3366

Medical Release Request

Name of Patient Date of Birth

____

Name, address, and phone number of physician requested to release medical records:

____
____
____
____

Release/send medical records to:
Stutz Dermatology
919 W. University Dr., Ste. 100
Rochester, MI 48307
P: 248-651-9500 F: 248-651-3366

____ Entire Chart
____ Office notes
____ Other: ______________________
____ Lab Work
____ Biopsy Results

The above named patient has requested that a copy of his/her medical records be released and sent to the aforementioned office. Please include a complete copy of his/her medical record.

I authorize the release of medical records including immunization records, HIV testing/results, mental health/chemical dependency, and any infectious disease records.

Patient Signature (Parent or Guardian): ____________________________________

Date: ________

Witness: ____ Date: __________