Release of Medical Records

Denton Dermatology

From: Dr. Sharif Currimbhoy

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I hereby authorize the release of my records, including laboratory/radiologic reports and results or copies of such as marked below, and I hereby request that such documents be promptly transferred **to**:

☐ All records

☐ Records from _____ to _____

☐ All pathology and lab results only

☐ Records from the past 2 years only

To (Doctor/Hospital): _____

Address: _____

City, State, Zip Code: _____

Phone: _____

Fax: _____

Patient Name (Printed): _____

Date of Birth: _____

Patient Signature: _____

Date: _____

This authorization shall be in effect until following specified date: Month: _____ Day: _____ Year: _____
or for two years from the date this document was originally signed or until transfer is completed.