Request for Medical Records

Denton Dermatology

To: Dr. Sharif Currimbhoy

Address: 209 N. Bonnie Brae, Ste 205

City, State, Zip Code: Denton, TX 76201

Phone: 940-382-1718

Fax: 940-380-9222

I hereby authorize that my medical records, or copies of such, be released to Dr. Currimbhoy and staff for continuity of care.

☐ All records

☐ Records from _____ to _____

☐ All pathology and lab results only

☐ Records from the past 2 years only

I hereby request that such documents be promptly transferred **from**:

From (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.