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Medical Records Release Form

Patient Name: Date of Birth:

I authorize Karimipour Dermatology to release my medical records / pathology report(s) to:

Recipient Name: _____

_____

Records to be released:

All records ☐ Office Visit Notes ☐ Pathology Reports ☐

Purpose for Disclosure:

Disability/FMLA ☐ Personal ☐ Continuing Care ☐

Other: _____

_____

Signature: _____

Date: _____

Witness (If applicable): _____