112 Columbia Point Drive, Suite 105
Richland, WA 99352
Tel: (509) 873-7140
Fax: (509) 818-1303

MEDICAL RECORDS RELEASE

(PLEASE PRINT)

I, ____ , authorize the release of my medical records from

____.
(Name of Practice)

Please send copies of my medical records to:
Tri-City Dermatology, PLLC
Columbia Point Drive, Suite 105
Richland, WA 99352
Fax: (509) 818-1303

Thank you,

____
(Signature)

____
(Printed Name)

____
(Phone Number)

____
(Date)