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DIPLOMATE
AMERICAN BOARD
OF DERMATOLOGY

AUTHORIZATION (REQUEST) FOR COPY OF PATIENT RECORDS

TO:_____
(Name)

_____
(Street)

_____
(City and Zip)

PATIENT:_____

PATIENT DATE OF BIRTH:_____

PLEASE SEND/FAX A COPY OF THE ABOVE PATIENT'S:

(Circle the choice)

a) COMPLETE MEDICAL RECORDS

b) HISTOPATHOLOGY REPORT(S)

c) LABORATORY REPORTS

d) OTHER:_____

TO: Alexander Miller, M.D.
17451 Bastanchury Rd. #103A
Yorba Linda CA 92886

Fax: (714) 961-0265

SIGNED:_____
(Signature of Patient or Parent/Guardian)

PRINT NAME OF PERSON SIGNING:_____
Circle: Patient / Parent / Guardian

WITNESS:_____DATE:_____
(Signature)