WEXLER DERMATOLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, hereby request that you,

Wexler Dermatology, PC

145 E. 32nd Street, 7th Floor

New York, NY 10016

Release to:

Dr. _____

Address: _____

_____

Phone #: _____

Fax #: _____

Email: _____

A report of my diagnosis, treatment, prognosis and recommendations, as well as other pertinent data related to your treatment of me.

Patient's Signature: _____ Date of Request: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Email (Optional): _____