THIRD PARTY AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ____, hereby request that you,

Dr. ____

Address: ____

____

Phone #: ____

Fax #: ____

Email: ____

Release to:

Wexler Dermatology, PC

145 E. 32nd Street, 7th Floor

New York, NY 10016

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): ____________________________________