

**Westmoreland Dermatology & Surgery Center**  
**Medical Records Release**  
**P.O. Box 8695**  
**Columbus, MS 39705**  
**(662) 243-2435 (Phone)**  
**(662) 328-7037 (Fax)**

**From:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**To:** \_\_\_\_\_

**Patient:** \_\_\_\_\_

**Birthday:** \_\_\_\_\_

**SS#:** \_\_\_\_\_

**I request a copy or summary of the following medical records:**

- **Complete medical record**
- **Biopsy Report (s)**
- **Lab Report(s)**
- **Consultation Reports**
- **Medication Allergies**
- **Surgical Procedures**
- **Other** \_\_\_\_\_

**For dates of service from** \_\_\_\_\_ **to** \_\_\_\_\_.

**Additional Comments:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**