WESTMORELAND

DERMATOLOGY & SURGERY CENTER

Medical Records Release

★ Patient:_____

★ DOB:_____

★ SSN:_____

I request a copy or summary of the following medical records to be released

To: _____ From: _____

_____Complete Medical Record

_____Consultation Report(s)

_____Medication Allergies

_____Records/Billing for a Cancer Policy

_____Pathology/Lab Report(s)

_____Operative Report(s)

_____Photographs

_____Other:_____

For dates of service from _____to_____.

Comments:_____

_____

_____

★ _____

Patient/Guarantor Signature Date

_____

Witness Date

Terry A. Westmoreland, M.D., F.A.A.D Misty T. Sharp, M.D., F.A.A.D Paula R. Hardy, FNP-BC

2110 Fifth Street North P.O. Box 8695 Columbus, MS 39705 Telephone: (662) 243-2435 Fax: (662) 328-7037