Mary T. Pentel, M.D.

Request for Release of Medical Records

Patient Name:_________________________________ Date of Birth:________________ S.S. #:____________

I, ______________________, hereby request my medical records be released to/from Southside Dermatolog

Patient or Guardian Signature:______________________________________ Date:______________________

Please send a copy or summary of the following medical records:

- ☐ Office notes Dates:
- ☐ Pathology report(s) Dates:
- ☐ Lab report(s) Dates:
- ☐ Operative report(s) Dates:
- ☐ Entire record
- ☐ Other:____

Please Send Medical Records To:

☐ Southside Dermatology
4727 Sunbeam Road
Suite 101
Jacksonville, Florida 32257
Phone: (904) 880-0622
Fax: (904) 880-0623

☐ Other Location:
☐ Self

Requesting Records From:

☐ Southside Dermatology

☐ Physician's Name:____

Address:____

City:_______________________ State:_____________ Zip Code:__________

Telephone:___________________________ Fax:_______________________