CAROLINA DERMATOLOGY
OF GREENVILLE

Patient Name: _____

Date of Birth: _____

MEDICAL RECORDS RELEASE

I, _____, authorize the release of my medical records from

_____.
(Name of Practice)

Please send copies of my medical records to:

_____

_____

_____

_____

Thank you.

_____
(Signature)

_____
(Date)

Carolina Dermatology, PA
920 Woodruff Road
Greenville, SC 29607
Phone: 864-233-6338
www.carolinaderm.com