

Request For Release Of Medical Records From:

Doctor's name: _____

Address _____

Phone: () _____

Fax: () _____

I hereby request that my (check applicable):

- Dermatology Medical Records
- Complete Medical Record
- All records from _____ to _____
- Lab work only
- Pathology Reports only

be release to:

Patricia A. Sinoway, M.D.
6800 N 79th Street, Suite 202
Niwot, CO 80503
Phone: (303) 652-9222
Fax: (303) 652-9333

Date: _____

Printed Name

Date Of Birth

Patients Signature

Witness Signature