Northshore Dermatology Center

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224-433-6423

MEDICAL RECORDS RELEASE FORM

Date:_____

To:_____

_____

_____

RE:_____

Date of Birth:_____

Please, release as soon as possible my medical records, labs, and biopsy results **TO/ FROM**:

Northshore Dermatology Center, S.C.
925 Sherwood Drive
Lake Bluff, Illinois 60044

Thank you for your prompt attention to this matter.

Patient Signature Date

_____ _____