

REQUEST FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize:

to send my medical record to

Corey L. Hartman, MD, FAAD

Skin Wellness Center of Alabama

2908 Central Avenue, Suite 150

Homewood, Alabama 35209

P: 205.871.7332

F: 205.871.7336

PLEASE SEND ALL CONTENTS OF MY CHART INCLUDING CLINIC NOTES,
LABORATORY & PATHOLOGY NOTES, AND ANY CORRESPONDENCE.

Please send this information as soon as possible by fax, mail or electronic transmission.

Thank you for your assistance in advance,

Signed:

Dated:

Print Name and Date of Birth:

If not signed by the patient, please indicate relationship: