



STUTZ DERMATOLOGY

455 S. LIVERNOIS, SUITE A12, ROCHESTER HILLS MICHIGAN 48307
PHONE: 248.651.9500 FAX: 248.651.3366

Medical Release Request

Name of Patient

Date of Birth

Name, address, and phone number of physician requested to release medical records:

Release/send medical records to:

Dermatology Center of Rochester Hills

455 South Livernois, Suite A12

Rochester Hills, MI 48307

P: 248-651-9500 F: 248-651-3366

Entire Chart
 Office notes
 Other: _____

Lab Work
 Biopsy Results

The above named patient has requested that a copy of his/her medical records be released and sent to the aforementioned office. Please include a complete copy of his/her medical record.

I authorize the release of medical records including immunization records, HIV testing/results, mental health/chemical dependency, and any infectious disease records.

Patient Signature (Parent or Guardian): _____

Date: _____

Witness: _____

Date: _____