Hancock Dermatology

400 W. Green Meadows Dr, Ste 110
Greenfield, IN 46140
Phone: 317-967-7921
Fax: 317-967-7122
www.hancockdermatology.com

Release of Medical Information

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Type of records released:

- ❑ All Records (including visit notes, chart notes, attachments, and pathology/lab documents)
- ❑ Lab / Pathology
- ❑ Visit Notes Only

I hereby request that my medical records be released:

TO:

Hancock Dermatology
Dr. Lori Sanford
400 W. Green Meadows Dr, Ste 110
Greenfield, IN 46140

FROM:

Physician / Facility Name: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

_____

Signature of Patient, Parent, or Authorized Representative Date

_____

Printed Name of Patient, Parent, or Authorized Representative Date

_____

Witness Date

This authorization is valid for 365 days following the date this document is signed.