300 E. Boyd Ave, #209
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
300 E Boyd Avenue Ste 209
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.