ST. CHARLES COUNTY
DERMATOLOGIC
SURGERY™

MEDICAL RECORDS RELEASE

PATIENT NAME _____
LAST, FIRST

ADDRESS _____
STREET

_____
CITY, STATE, ZIP CODE

DATE OF BIRTH _____
MONTH / DAY / YEAR

I HERBY AUTHORIZE _____
PHYSICIAN'S NAME

_____
PHYSICIAN'S PHONE NUMBER

_____
PHYSICIAN'S FAX NUMBER

_____
PHYSICIAN'S ADDRESS (IF KNOWN)

TO RELEASE MY MEDICAL RECORDS VIA MAIL/FAX TO:

St. Charles County Dermatologic Surgery
Dr. Stacey Tull
1493 Cottleville Parkway
Cottleville, Missouri 63376
Phone: 636-317-DERM
Fax: 636-244-1197

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

If you have any questions, please feel free to contact our office. Thank you.