The Gainesville Skin Cancer Center

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CONSENT TO RELEASE MEDICAL INFORMATION AND RECORDS

Please list any person, including relatives and physicians on the lines provided below that you give consent to receive any of your medical information or records:

I _____, (patient name) give permission to Dr. Charles B. Stoer and Dr. Daven N. Doshi to release any or all medical information or records on file to **myself** and:

Name: _____ Relation to Patient/Phone: _____

Name: _____ Relation to Patient/Phone: _____

Name: _____ Relation to Patient/Phone: _____

Name: _____ Relation to Patient/Phone: _____

Physician's name: _____ Physician's phone number: _____

Physician's name: _____ Physician's phone number: _____

Physician's name: _____ Physician's phone number: _____

Patient's signature: _____ Date: _____

5/2016