WATT DERMATOLOGY
DISEASES & SURGERY OF THE SKIN

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1) NAME: _____ DOB: _____

2) I Authorize, Watt Dermatology, Dr. James R. Watt; 216A S. Apopka Ave Inverness, Fl 34452

3) TO DISCLOSE: TO RECIEVE: (Circle one)

All Records or Pathology Reports only Specific: _____

4) I hereby request that my records be sent To/ From:

_____
Name of Physician/Office Phone: Fax:

5)Dates to be disclosed: From:_____To:_____

6) This medical records request will expire exactly twelve months from the date signed by patient.

7)_____
Signature of patient/ Legal rep Date