SPECIALISTS IN DERMATOLOGY

REQUEST FOR MEDICAL RECORDS

Patient Name:_____ **DOB:** _____

Patient Address: _____
_____
_____

Requesting Records From:

Brent A. Shook, MD Robert Cook-Norris, MD
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3786 FM 1488 Suite 200
The Woodlands, TX 77384
FAX (281) 364-8833

Please send the following requested records to:

_____
_____
_____
_____

□ Pathology Report
□ Medical History
□ Exam Notes
□ All Records
Other: _____

I authorize the transference of the above stated medical records. I also understand and agree that I am financially responsible for all fees, if any, associated with my request, including copying charges, supplies, postage, labor, etc.

_____ _____
Signature of Patient/Legal Guardian Date