SPECIALISTS IN DERMATOLOGY

REQUEST FOR MEDICAL RECORDS

Patient Name:_____ **DOB:**_____

Patient Address: _____
_____
_____
_____

Requesting Records From:

_____
_____
_____
_____

Please send the following requested records to:

Brent A. Shook, MD Robert Cook-Norris, MD
Susannah Andrews, MMS, PA-C Michelle Purtle, PA-C
Melissa Shearer, PA-C Jessica Rushing, PA-C Jennifer Buffard,NPC
3786 FM 1488 Suite 200
The Woodlands, TX 77384
Fax: 281-364-8833

□ 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

_____
Printed Name of Patient/Legal Guardian