FORCARE
MEDICAL CENTER

Please complete the following information:

Patient Name: _____

Date of Birth: ___/___/____ Last 4 SSN: _____

Please send the above listed record(s) **from**:

Provider: _____

Address: _____

Phone #: _____ Fax #: _____

I request a copy/summary of the following medical records:

- ☐ Complete Medical Record(s)
- ☐ Lab Report(s)
- ☐ Allergy Test/Treatment
- ☐ Other: _____
- ☐ Biopsy Report(s)
- ☐ Consultation Report(s)
- ☐ Surgical Procedure(s)
- ☐ All

I authorize the records **to**:

Forcare Medical Group-Dermatology
15416 N. Florida Ave
Tampa, FL 33613
Phone #: (813)960-2400
Fax #: (813)960-2410

Provider: _____

This authorization shall not be valid for greater than one year from the date of signature.

Print Name: _____ Date: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____