THE BOWMAN INSTITUTE
FOR DERMATOLOGIC SURGERY

Dear

The patient whose signature appears below states that he/she was under your medical care in the past. We are requesting a complete copy of your medical records, x-rays, laboratory reports, etc. for the following patient:

_____
PATIENT NAME (PRINT)

Please send the records to:

The Bowman Institute for Dermatologic Surgery
Attn: Medical Records
5379 Primrose Lake Circle Tampa, FL 33647
Fax: (813) 977-3886

SIGNED PERMIT FOR THE RELEASE OF INFORMATION

I, the undersigned, hereby permit the above physician, hospital, or clinic to release to ***The Bowman Institute for Dermatologic Surgery*** any and all information contained in my medical records, identifiable by the following:

Birth Date: _____

Signature: _____ Date: _____