TWIN PEAKS DERMATOLOGY, PC

JOHN FUESTON, MD

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY   FELLOW AMERICAN ACADEMY OF DERMATOLOGY

Request for medical records

Date: _____________

PATIENT NAME:_____________________
PATIENT'S DATE OF BIRTH:_____________________
PATIENT'S SOCIAL SECURITY #:_____________________
PATIENT'S OR GUARDIAN'S SIGNATURE:___________________

Please circle all records wanted: Chart Notes, Biopsy Reports, Lab Results, Complete Records

FROM:		**SEND TO:**	
Name:	Twin Peaks Dermatology, PC	Name:	_____________________________
Address:	205 South Main St.	Address:	_____________________________
	Suite E		____________________________
Phone:	303-485-8913	Phone:	_____________________________
Fax:	303-485-8914	Fax:	_____________________________

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