BELLA DERMATOLOGY
Records Release Form

Date: _____

Please release medical records for:

Name _____ Date of birth_____

Please include the following:

- [ ] Progress Notes
- [ ] Laboratory work, including pathology reports
- [ ] History
- [ ] Billing information
- [ ] Other: _____

From:

Name of Practice or Physician: _____

Address: _____

City:_____ State _____ Zip Code:_____

Phone:_____ Fax: _____

To:
Bella Dermatology
6120 Mae Anne Ave., Suite 1
Reno, NV 89523
Phone: 775-746-0196
Fax: 855-873-0927

Thank you,

Printed Patient Name: _____

Patient (or Guardian) Signature: _____

BELLA DERMATOLOGY
6120 Mae Anne Ave., Suite 1
Reno, NV 89523
775-746-0196