Robert C. Rau, M.D.
Michael P. Conroy, M.D.
Patricia G. Malerich, M.D.
Mary Jo Kerns, M.D.

DGC
DERMATOLOGISTS
OF GREATER COLUMBUS
Dublin • Upper Arlington
Board Certified Dermatologists

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

DATE: _____

TO:

_____

_____

_____

_____

I hereby request that my records be forwarded to:

_____

_____

_____

_____

By signing below, I hereby grant my voluntary consent to disclose any portion of my otherwise confidential medical information in any format including, but not limited to laboratory slides related to my medical care to the above named person.

Patient Name: _____ Date of Birth: _____

Signature of Patient or legal guardian: _____

Witness Signature: _____