Orlando Dermatology, Inc.

Farooq Lateef, MD, F.A.C.P., F.A.A.D.

6001 Vineland Road Suite 116
Orlando, FL 32819

MEDICAL RECORDS RELEASE

I, _____ (DOB ____/____/____) herein
Patient Name

request of: *(Please check one)*

□ **Orlando Dermatology**
6000 Turkey Lake Road, Suite 110
Orlando, FL 32819
Phone: (407) 351-1888
Fax (407) 226-9804

OR □_____
_____
_____
_____
_____
(Physician's Name, Address, Phone/Fax Number)

to forward a copy or summary of the following medical records:

□COMPLETE MEDICAL RECORDS
□ PATHOLOGY REPORTS
□ LAB REPORTS
□ CONSULTATION REPORT
□ ALLERGY TEST/TREATMENT
□ SURGICAL PROCEDURES

For dates of service: _____ to _____

To: *(Please check one)*

□ **Orlando Dermatology**
6000 Turkey Lake Road, Suite 110
Orlando, FL 32819
Phone: (407) 351-1888
Fax (407) 226-9804

OR □_____
_____
_____
_____
_____
(Physician's Name, Address, Phone/Fax Number)

_____ ____/____/____
Patient/Representative Signature Date

_____ ____/____/____
Witness Signature Date