

Dermatology Specialist of Naples

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RECORD RELEASE

Physician's Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered me.

Patient:

DOB:

Date:

Signature _____

Please release my records to:

Cynthia R Strohmeyer, M.D.
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Naples, FL 34102
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