

# Dermatology Specialist of Naples

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## RECORD RELEASE

**FROM: CYNTHIA R. STROHMEYER, M.D.**

**Patient Name:**

**Patient DOB:**

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

Please release my records to:

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature \_\_\_\_\_