



Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Kathryn O. Lockett, MD, FAAD
Brittany Rigsby, CRNP
Alison Hayes, CRNP
Michelle Dumestre, PA-C

Request for Release of Medical Information

I hereby authorize:

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Kathryn O. Lockett, MD, FAAD
Brittany Rigsby, CRNP
Alison Hayes, CRNP
Michelle Dumestre, PA-C

Skin Wellness Center
3415 Independence Dr, Suite
200 Birmingham, AL 35209
Phone: 205.871.7332
Fax: 205.871.7336

To send my medical record to:

PLEASE SEND ALL CONTENTS OF MY CHART INCLUDING CLINIC NOTES, LABORATORY & PATHOLOGY NOTES, AND ANY CORRESPONDENCE.

Please send this information as soon as possible by fax, mail, or electronic transmission.

Thank you for your assistance in advance,

Signed _____

Dated _____

Print Name _____ Date of Birth _____

If not signed by the patient, please indicate relationship _____

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