



JORDAN VALLEY
DERMATOLOGY

Records Release Request

I, (Print Name) _____, Date of Birth, _____
authorize the release of my records from:

Jordan Valley Dermatology Center

Douglass W. Forsha, M.D.
3570 West 9000 South, Ste. 220
West Jordan, UT 84088

I authorize the release of:

- All Medical Records
- Pathology/Lab Reports
- Records dated _____ to _____
- Other (Please Specify) _____

To be released from the following party:

Patient Signature _____ Date _____

Douglass W. Forsha M.D
3570 West 9000 South Suite #220, West Jordan Utah 84088
Phone (801) 569-1456 Fax (801) 565-7931