ZAND
DERMATOLOGY

Request for Release of Medical Records

Instructions to patient: Please sign this form and send it to your prior dermatology office – via fax, mail, or email – to request that a copy of your medical records be sent to Zand Dermatology. This is best done 2-4 weeks prior to your scheduled appointment. Thank you in advance!

I authorize the release of confidential health information about me, by requesting that my medical records be released from:

☐ Cosmetic & Laser Surgery Institute (Dr. Parnell's office)
1030 Sir Francis Drake, Suite 110, Kentfield, CA 94904
Email: info@dermatologymarin.com
Fax: (415) 461-1043

☐ Greenbrae Dermatology (Dr. Tanasovich's office)
1300 South Eliseo Drive, Suite 207, Greenbrae, CA 94904
Fax: (415) 925-9062

☐ Other: _____

Please send a copy of my complete medical records, including pathology reports, to Zand Dermatology:

Dr. Sarvenaz Zand
Fax: (844) 719-5148

Patient name: _____

Patient DOB: _____

Patient signature: _____

Date: _____

Thank you!