Bluegrass Dermatology
Skin Surgery Center, P.S.C.
Buker Office Based Surgery, P.L.L.C.

Medical Records Release

John L. Buker, M.D.
Patricia H. Buker, M.D.
Donna E. Roth, M.D.
Dana R. Black, M.D.
Danelle Owens, PA-C

PATIENT'S NAME ______________________________ Patient's Date of Birth ______________

I, ____, hereby authorize

Bluegrass Dermatology to release my records to:

NAME ____

ADDRESS____

PHONE ____

If you would prefer we fax your medical records please list the appropriate fax number below:

Release to Fax # ____

Specific reason for the release of medical information for use or disclosure:

____

____ ____________________

Signature of Patient / Parent or Guardian Today's Date

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