Sandra Surbrugg, M.D., Kathleen Thomas, M.D., Julie Neville, M.D., Mary Cole, M.D.,
Paul Massey, M.D., Krystal Massey, M.D., Heather Roberts, FNP-C, Caitlyn McCue, P.A.,
Alissa B. Aylward, PA-C

Date: ___________________________________

Patient: ____ DOB: _________________________

Address__________________________ City_______________ State___________ Zip________

Hereby Authorize:____

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To release to: ____

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Copies of my medical records to include ____

____

Dated from____________________________________ to_________________________________

Please note: A $25 prepaid fee or a per page fee will be charged at our discretion to patients when they request their records for personal use or to be sent to third parties (i.e. attorneys, insurance, disability, or other sources). However, no fee will be charged if the records are sent directly to another continuing care provider. (i.e. physician, hospital, or clinic). Copies of records will be available in 5 to 7 business days.

____ ______________________________________
Signature Witness

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123 WESTERN HILLS BOULEVARD CHEYENNE, WY 82009
307.635.0226 800.736.0226 FAX 307.635.1924
WWW.CHEYENNESKINCLINIC.COM