John K. Wildemore M.D.
Board Certified Dermatologist

Authorization To Transfer Medical Records

Last Name_____First _____M.I._____D.O.B_____

I hereby authorize (Physician/Practice Name)_____to send a copy of my medical records to:

_____
Name

_____
Mailing Address

_____
City State Zip Code

_____
Phone Number Fax Number

Any and all information may be released, except as specified below:

_____
_____
_____

This authorization is effective as of now and will remain effective unless otherwise revoked.

_____
Patient Signature Date

744 W. Lancaster Ave
Devon Square II, Suite 230
Wayne PA 19087
610-688-8750