# 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.
10654 S River Heights Drive, Ste. 210
South Jordan, UT 84095

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
10654 S River Heights Drive, Ste 210 South Jordan, UT 84095
Phone (801) 569-1456 Fax (801) 565-7931