FLORIDA DERMATOLOGY SPECIALISTS

Patient Record Request
Richard A. Krathen, MD

Patient: _____

DOB: _____

Requests that all pathology reports and office visits from _____ are transferred electronically via email to **Florida Dermatology Specialists, PLLC at records@flderms.com**, or sent to our **efax at 772-872-5312** for continuation of care.

Thank you for your prompt attention to this matter.

Signed: _____

___ Patient ____ Patient's Legal Guardian/POA

Date: _____

This Authorization, good for two years, may be revoked at any time in writing by the patient above.