Date: [Insert Date]

To: [Primary Care Physician/Clinic Name]
Address: [Clinic Address]

Subject: Consent to Release Medical Records to Dermatology Specialist

To Whom It May Concern,

I, **[Patient Full Name]**, date of birth **[Patient Date of Birth]**, hereby authorize the release and forwarding of my medical records to the dermatology specialist listed below:

Specialist Name: [Dermatologist Name]
Clinic Name: [Dermatology Clinic Name]
Fax/Email: [Recipient Contact Info]

The information to be released includes:

- Recent clinical notes regarding [Specific Skin Condition]
- Laboratory and pathology reports (including biopsy results)
- Relevant diagnostic imaging
- Current medication list

This authorization is valid for one year from the date of signature or until I provide written notice of revocation. I understand that this information is being shared for the purpose of ongoing medical treatment and consultation.

Thank you for your prompt assistance in this matter.

Sincerely,

_____
[Patient Signature]

Patient Phone Number: [Insert Phone Number]