DERMATOLOGY

ASSOCIATES OF ITHACA

# Request for Medical Records

To:

_____

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Please release your records for the patient named below to:

Josephine C. McAllister, M.D.
2333 North Triphammer Road
Suite 203
Village Office Campus
Ithaca, NY 14850

Patient: _____

Date of Birth (mm/dd/yyyy): ___/___/_____

Signature: _____

Today's Date: _____