LAING DERMATOLOGY & SKIN CANCER CENTER, PA
6807 Knightdale Blvd., Suite C
Knightdale, NC 27545
Office: 919 217-5510

Medical Request form

To: Physician Name or Practice name:_____
Address:_____

_____

_____

_____

Phone:_____
Fax:_____

I request the above named physician and/or practice send the following medical records:

___ complete medical record
___ specific office visit notes. Please specify date(s):_____
___ lab/biopsy results only(circle which one). Please specify dates(s):_____
___other (please specify)_____

on Patient Name_____
Patient Date of Birth_____
Patient Address_____

_____

_____

_____

Send to:
Laing Dermatology and Skin Cancer Center, PA
6807 Knightdale Blvd., Suite C
Knightdale, NC 27545

Signature of Patient_____Date:_____

Signature of Witness_____Date:_____