

DERMATOLOGY ASSOCIATES OF THE NORTHEAST, PC
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03443
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Information about you:

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____

Street

City

State

Zip

I HEREBY AUTHORIZE DERMATOLOGY ASSOCIATES OF THE NORTHEAST, PC TO
TRANSFER ALL OF MY RECORDS TO: REBECCA M. JONES, MD LLC AT: 181 STATE
ROAD, WHATELY, MA 01093.

Signature

Date

This authorization is valid for 90 days and may be revoked at any time prior to.