

Rebecca M. Jones, MD., LLC

Dermatology

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Information about you:

Patient Name:

_____ DOB: _____

Address:

I hereby authorize release of requested information from Rebecca M. Jones, MD., LLC. at 138 Elliot Street Brattleboro, VT 05301

To: _____

Information Requested: _____

Check here for all records to be released: _____

Signature

Date

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