Internal Use Only
Provider's Initials _____
Staff's Initials _____
Date processed _____

Medical Records Release

Current Date:_____

From: _____ _____
Patient Name (please print) Date of Birth mm/dd/yyyy

_____
Current P.O. Box or Street Name City State Zip Code

_____
Telephone Number (Home) (Work) (Cell)

To: □New Dermatologist □Primary Care Physician □Myself □Other-_____

_____
Name of person records are being sent to (if to you, please write 'self') Telephone Number Fax Number

_____
Current P.O. Box or Street Name City State Zip Code

I am requesting a copy of the following records:

□All Records from APDerm
□Medical Records for date(s) of service from_____to_____ from APDerm
□Biopsy Report(s) from APDerm □Lab Reports from APDerm
□Surgical Procedure(s) from APDerm □Mohs Surgery from APDerm
□Photographs (25¢/photo if not in electronic format) from APDerm
□Other from APDerm (please specify) _____

Reason for requesting record(s):_____

_____ _____
Patient, Parent, or Legal Guardian Signature **Date**

_____ _____
Witness **Date**

Method of Payment
□Visa □Master Card □ AMEX
□Check or Money Order enclosed (make check payable to Adult & Pediatric Dermatology, pc)
**Please return a copy of this request with your check or money order

Credit Card Number (this information will be destroyed after processing) Expiration Date VCode (back of card)

_____ _____/_____ ___ ___ ___ ___

_____
Authorized Signature for credit card transaction

Fee's:
Patient requesting record: $15.00 (1-100 pgs)
Transferring to new Dermatologist: $15.00 (1-100 pgs)
Attending Physician's Statement/Certified Medical Records: $50.00
Primary Care Physician: $No charge
Life Insurance Company $50.00

All records will be released once payment has been received. All records will be photocopied and mailed within two weeks time. 6/09