

<b>Internal Use Only</b> Provider's Initials _____ Staff's Initials _____ Date processed _____
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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 <input type="checkbox"/> Visa <input type="checkbox"/> Master Card <input type="checkbox"/> AMEX <input type="checkbox"/> 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) Primary Care Physician: \$No charge  
 Transferring to new Dermatologist: \$15.00 (1-100 pgs) Life Insurance Company \$50.00  
 Attending Physician's Statement/Certified Medical Records: \$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