CHARLOTTESVILLE DERMATOLOGY PLC

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Medical Records Release

Please send my records to:

Doctor _____

Address _____

_____

Phone _____

Fax _____

Please send my records from:

Doctor _____

Address _____

_____

Phone _____

Fax _____

- ☐ Complete Medical Record
- ☐ Biopsy Report(s)
- ☐ Lab Report(s)
- ☐ Consultation Report(s)
- ☐ Medication Allergies
- ☐ Allergy Test/Treatment
- ☐ Surgical Procedures
- ☐ Other _____

Please check one:

- ☐ For dates of service from ____/____/____ to ____/____/____
- ☐ For all date of service

Please check one:

- ☐ Mail my records
- ☐ Fax my records
- ☐ I will pick my records up

Additional Comments: _____

_____

I understand that there may be a reasonable medical records copying fee as permissible by State Law.

Patient's Signature: _____ Date: _____

Printed Name: _____ Date or Birth: _____

Patient Address: _____

_____

Patient Phone Number: _____