CHARLOTTESVILLE DERMATOLOGY PLC

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Medical Records Release

Please send my records to:

Doctor:______________________

Address _____________________

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Phone_______________________

Fax__________________________

Please send my records from:

Doctor:________________________

Address________________________

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Phone__________________________

Fax_____________________________

Complete Medical Record

Lab Report(s)

Medication Allergies

Surgical Procedures

Biopsy Report(s)

Consultation Report(s)

Allergy Test/Treatment

Other____________________________

Please check one:

For dates of service ___/___/___ to ___/___/___

For all dates of service

Please check one:

Mail my records

Fax my records

I will pick my records up

Additional comments:

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

Patients Signature_____________________________ Date:_____________________

Printed Name:________________________________ Date of Birth:_______________

Patient Address:____

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Patient Phone Number:________________________