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: ____

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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: ____

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Patient Phone Number: ___________________________________