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

Fees:
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

Please mail this completed form along with your payment to:

Adult & Pediatric Dermatology, p.c.
Attn: Medical Records
1620 Sudbury Road
Concord, MA 01742

All records will be released once payment has been received. All records will be photocopied and mailed within two weeks' time. 4/12