Adult & Pediatric Dermatology, PC

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
526 Main Street, Suite 302
Acton, MA 01720

All records will be released once payment has been received. All records will be photocopied and mailed within two weeks' time. 1/15