DERMATOLOGY SOUTHWEST

Records Release Request Form

Name of Patient: _____

Date of Birth: ___/___/___

Name of individual requesting records if other than patient:

_____

Date of Request: ___/___/___

Patient's Address_____
Street address Apt. #

_____
City State Zip Code

Please note that the records will only be sent to the address indicated in the patient's chart and the address on the patient's driver's license. If the two do not match, you will have to appear in person to obtain this information.

Please indicate which part or parts of your medical record you are requesting

❑ Entire Record

❑ Only records between the following dates of service:

From ___/___/___ to ___/___/___

❑ Other (Please be specific)

_____

_____

_____

I have included:

❑ Copy of Drivers License or other government issued photo I.D.

❑ $35.00 payment for copying and other costs associated with release of records.

_____ _____ _____
Patient Signature (or Legal Guardian) Printed Name Date