DeVore Dermatology, P.A.

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REQUEST TO ACCESS MEDICAL OR BILLING RECORDS

Today's Date_____ Patient's Name_____

Chart No._____ Social Security No._____

Date of Birth _____

Mailing Address_____City_____State_____Zip_____

Telephone # (H)_____ (W)_____

Describe the information and dates of service(s) that you would like to access (ie: physician notes, recording of lab test results, x-rays, etc…) Make sure to include date(s) of service.

_____

_____

Check **one** of the following:

☐ Please **release** my records **to**: _____
Physician Name

_____
Mailing Address

_____
City State Zip Code

_____
Phone **Fax**

☐ Please **obtain** my records **from**: _____
Physician Name

_____
Mailing Address

_____
City State Zip Code

_____
Phone **Fax**

Signature*_____ Date:_____

***If you are not the patient, please fill in the following:**

Name_____
Relationship to Patient_____
Address (if different than above) _____
Phone (if different than above) (H)_____ (W) _____