Annapolis Dermatology Center

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Authorization for Release of Medical Records

RECORDS TO:

_____
_____
_____

RECORDS FROM:

_____
_____
_____

PATIENT INFORMATION (Please Print):

Name: _____
Date of Birth: ____/____/____ **Phone:** _____-_____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Reason for Request: _____

I request a copy of all medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

Note: Copy and Preparation Fees may apply.

Mail/FAX to:

Annapolis Dermatology Center
71 Old Mill Bottom Road North, Suite 300
Annapolis, MD 21409
Fax: (410) 268-8171

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

_____ _____
Patient/Guardian Signature **Date**

_____ _____
Witness **Date**

_____ _____
Supervising Physician **Date**