

MEDICAL RECORDS REQUEST

PLEASE CHECK APPROPRIATE BOX:

Section 1. Request for us to forward your records to another doctor.

This authorizes our office to forward copies of your medical records to the following:

TO: _____

Section 2. Request to have your patient records forwarded to our office from another doctor at the following address:

Brinton Lake Dermatology
500 Evergreen Drive, Suite 20
Glen Mills, PA 19342 Phone: 484-785-3376

This is your authorization for another doctor to forward copies of your medical records to us.

(PATIENT PRINTED NAME)

(PATIENT SIGNATURE)

(PATIENT DATE OF BIRTH)

(DATE)

PLEASE DO NOT FAX RECORDS!!!!!!!!!!!!