BEACHES DERMATOLOGY

www.beachesdermatology.com

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Request for Release of Medical Records

Patient Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: XXX-XX-_____(last 4 digits only)

☐ **Records request <u>from</u> Beaches Dermatology to be transferred to:**
Name of Person or Facility: _____
Practice Address: _____
City, State, Zip: _____ Phone: _____
Email: _____ Fax: _____

☐ **Records request to be <u>sent to</u> Beaches Dermatology from:**
Name of Previous Physician: _____
Practice Address: _____
City, State, Zip: _____ Phone: _____
Email: _____ Fax: _____

Please send records to:

☐ Fernandina Beach
Fax: 904.261.2166

☐ Ponte Vedra Beach
Fax: 904.273.0410

☐ St. Augustine
Fax: 904.287.8885

☐ Atlantic Blvd
Fax: 904.221.3102

Please select all that apply to your request:

☐ Complete Medical Records
☐ Clinic/Progress Notes
☐ Pathology Reports
☐ Other: _____
☐ Communication Notes
☐ Radiology Reports
☐ Physician Order
☐ History and Physical
☐ Operative Reports
☐ Nurse Notes

Please select the purpose of your request:

☐ Continued patient care
☐ Transferring to new Derm
☐ Other: _____
☐ Personal
☐ Attorney/Legal
☐ Workers Comp/ SS/ Disability
☐ Insurance

I hereby authorize Beaches the above request:

_____ _____
Signature of patient or Legal Guardian Date