Dermatology *Partners,* Inc.

MEDICAL RECORDS REQUEST
BY PATIENT

Date of Request: _____

PATIENT INFORMATION:

Name of Individual Completing Request: _____

Patient Name: _____ Date of Birth: _____

Guardian Name (If applicable): _____

Phone Number: _____

NEW PRACTICE INFORMATION (where forms will be sent):

Name of Practice: _____

Provider Name: _____

Practice Address (to send records to): _____

_____

_____

Purpose: ☐ Medical Care ☐ Insurance ☐ Personal

Other: _____

INFORMATION TO BE RELEASED:

☐ **Entire Medical Record** Dates _____

☐ Medical Record Summary Dates _____

☐ Clinic / Progress Notes Dates _____

☐ Labs / Pathology Results Dates _____

☐ Operative Reports Dates _____

Patient Signature: _____ **Date:** _____

Please allow up to 14 days for processing. Form must be filled out completely or it may delay processing. *Please fax, mail or drop request off. 65 Walnut Street, Suite 480, Wellesley, MA 02481*
Office Phone: 781-431-7733 / Office Fax: 781-235-2665