BRYN MAWR DERMATOLOGY

Medical Records Release Form

I hereby authorize Bryn Mawr Dermatology to release medical records of:

Patient Name _____

Address _____

City, State and Zip Code _____

Phone _____

Date of Birth _____

Records to be released to:

Name of Person and/or Facility _____

Address _____

City, State and Zip Code _____

Phone _____ Fax _____

Email _____

Records to be release via (select all that apply)

☐ Mail ☐ Fax ☐ Email

Include copies of:

☐ Entire Medical Record
☐ Pathology/Biopsy Reports
☐ Lab/Bloodwork Results

Select the purpose of your request:

☐ Change in Medical Provider
☐ Personal
☐ Other _____

X _____ _____

Signature of Patient / Legal Guardian / Authorized Representative — Date

NOTE: Please allow 7-10 business days for processing.
Release of records may be subject to a $25 fee.