

Medical Records Release Form

Address	Thereby authorize Bryn Mawr Dermatology to release medical records of.
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 Entire Medical Record Pathology/Biopsy Reports Lab/Bloodwork Results Select the purpose of your request: Change in Medical Provider Personal Other	Patient Name
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 Entire Medical Record Pathology/Biopsy Reports Lab/Bloodwork Results Select the purpose of your request: Change in Medical Provider Personal Other	Address
Records to be released to: Name of Person and/or Facility	City, State and Zip Code
Records to be released to: Name of Person and/or Facility	Phone
Name of Person and/or Facility	Date of Birth
Address	Records to be released to:
City, State and Zip Code Phone Fax Email Records to be release via (select all that apply) Mail	Name of Person and/or Facility
Phone Fax	Address
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	City, State and Zip Code
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☐ 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	Descards to be release via (select all that apply)
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Pathology/Biopsy Reports Lab/Bloodwork Results Select the purpose of your request: Change in Medical Provider Personal Other	·
Select the purpose of your request: Change in Medical Provider Personal Other	
☐ Change in Medical Provider ☐ Personal ☐ Other	Lab/Bloodwork Results
Personal Other	Select the purpose of your request:
Other	
	Other
X Signature of Patient / Legal Guardian / Authorized Representative Date	X