BRYN MAWR DERMATOLOGY

RECORDS RELEASE FORM

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

Patient Name: _____

Phone: _____

Date of Birth: _____

Records to be released to:

Name of Person and/or Facility: _____

Street Name & Number: _____

City, State and Zip Code: _____

Phone: _____ Fax: _____

Email _____

Records to be release via (select all that apply):

- ☐ Mail
- ☐ Fax
- ☐ Email

Include copies of (Check one or more):

- ☐ Entire Medical Record
- ☐ Particular Date(s) of Service | Date(s): _____
- ☐ Pathology/Biopsy Reports | Date(s): _____
- ☐ Lab/Bloodwork Results | Date(s): _____

Select the purpose of your request:

- ☐ Change in Medical Provider
- ☐ Personal
- ☐ Other _____

X _____ _____

Signature of Patient / Legal Guardian / Authorized Representative Date

COMPLETE, SIGN, AND EMAIL THIS FORM TO: records@brynmawrdermatology.com

Please allow 7-10 business days for processing.