DERMATOLOGY
LASER CENTER
MEDICAL DAY SPA
COSMETIC SURGERY

bodian dermatology

11 GRACE AVENUE | GREAT NECK, NEW YORK 11021
T: 516 482 2882 | F: 516 482 6039 | www.bodianderm.com

Dear Sir or Madam:

Please complete the attached form in its *entirety.*
Dr. Bodian's information should appear on the top portion under "Name of Physician." One the bottom portion under "To Doctor or Facility Name," that is where the records are to be sent.

There is a **$.75 per page** charge for copying the records. Upon receipt of your signed authorization we will call you to advise you of the cost. To facilitate processing, you may remit payment by credit card or send a check made payable to Bodian Dermatology Group, P.C.

If you have any questions, please contact the medical records department at (516) 482-2882.

Thank you.

Bodian Dermatology Group, P.C.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ _____ herein request of
Print Patient's Name Date of Birth

Adam B. Bodian, MD/ Bodian Dermatology Group, PC
11 Grace Avenue, Suite 100
Great Neck, NY 11021

to forward a copy of the following medical records:

_____ Complete Medical Records
_____ Biopsy Report (s)
_____ Lab Report (s)
_____ Consultation Reports
_____ Allergy Test/Treatment
_____ Surgical Procedures

For dates of service from _____ to _____

Please send to Doctor or Facility Name:

_____

_____

_____

Phone Number/ Fax Number

_____

_____ _____
Patient Signature Date