LEGACY
DERMATOLOGY

REQUEST FOR RELEASE OF MEDICAL RECORDS

In order to legally transfer your medical records from one physician's office to another, please complete this form and fax/email/hand-deliver this form to the office from which you would like your records transferred.

Patient information (please print or type):

Patient Name____Date of Birth:_____________

Address_______________________________City_____________State___________Zip_______

Phone________________________________Email_____________________________________

Name of Medical Practice FROM WHICH records are being requested________________

Address_____________________________Phone_________________Fax__________________

PLEASE RELEASE MY MEDICAL RECORDS, via fax or email, **TO**:

LEGACY DERMATOLOGY
Dr. Jennifer Dharamsi, M.D.
3140 Legacy Drive, Suite 110
Frisco, Texas 75034
972-469-2626 (phone)
972-999-4656 (fax)
drd@legacydermatology.com

ANOTHER LOCATION:
Name of Practice Or Physician:
____
Address:
____
Fax number and/or email where we should send your records:
____

PLEASE RELEASE THE FOLLOWING MEDICAL RECORDS:

Clinic Notes	All	Most recent 3 records	Specific date range____________
Laboratory Results	All	Most recent 3 records	Specific date range___________
Pathology Results	All	Most recent 3 records	Specific date range____________
Full Medical Record			

I understand that all information obtained by the recipient will be held confidential in accordance with HIPAA privacy laws (copy of Notice of Privacy Practices of Protected Health Information available upon request). I may revoke this consent at any time. BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS.

Signature ___X____Date_________________