Shah DERMATOLOGY

Center for Advanced Aesthetics

Medical Records Request Form

Patient's Name _____ DOB (MM/DD/YYYY) _____ Today's Date _____

Patient's Address _____ City _____ State _____ Zip _____

Primary Phone Number _____

I authorize the following physician or facility to release information:

Physician Name: _____

Facility Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Please release Medical Records to:

Shah Dermatology, LLC
37767 Market Drive, Suite 200
Charlotte Hall, MD 20622
P 301.884.0278
F 301.884.8663

Please include:

- ☐ All Records (including all notes, lab, and pathology reports)
- ☐ Clinical Notes
- ☐ Lab and Pathology Results
- ☐ Other: _____

I understand that my authorization will remain effective from the date of my signature for 365 days after, and that the information will be handled confidentially in compliance with all applicable federal laws. In addition, I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

Patient/Representative Signature _____ **Date** _____

Print Name _____ **Witness Signature** _____