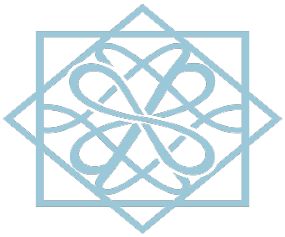

LEGACY
DERMATOLOGY &
RESTORATION CENTER

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)

frontoffice@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_____

LEGACY DERMATOLOGY
3140 Legacy Dr, Suite 110
Frisco, Texas 75034

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