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**
3140 Legacy Drive, Suite 110
Frisco, Texas 75034
972-469-2626 (phone)
972-999-4656 (fax)
frontdesk@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_____