

## MEDICAL RECORDS REQUEST

### PLEASE CHECK APPROPRIATE BOX:

**Section 1. (  ) Request for us to forward your records to another doctor.**

**This authorizes our office to forward copies of your medical records to the following:**

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 2. (  ) Request to have your patient records forwarded to our office from another doctor at the following address:**

Brinton Lake Dermatology  
500 Evergreen Drive Suite 20  
Glen Mills, PA 19342 Phone: 484-785-3376

**This is your authorization for another doctor to forward copies of your medical records to us.**

\_\_\_\_\_  
(PATIENT PRINTED NAME)

\_\_\_\_\_  
(PATIENT SIGNATURE)

\_\_\_\_\_  
(PATIENT DATE OF BIRTH)

\_\_\_\_\_  
(DATE)

## PLEASE DO NOT FAX RECORDS!!!!!!!!!!!!