

MEDICAL RECORDS REQUEST

TO: _____ FAX # _____
Print Doctor's Name

I, _____ DOB _____
Print Patient's Name

MRN

PHYSICIAN/NP/PA

Request a copy of my:

- medical records
 pathology reports
 other _____

FORWARD TO:

**Premier Dermatology & Cosmetic Surgery
Apex Medical Center
537 Stanton – Christiana Road
Newark, DE 19713
Phone - 302-633-7550
Fax – 302-633-7556
Email: Info@premierdermde.com**

CONSENT: I acknowledge that the information provided may contain sensitive and confidential medical data. I authorize the release of this information and confirm it to be voluntary.

Patient's Signature (Guardian)

Date

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