SUNWISE
Family Dermatology & Surgery

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To:_____ **Fax #:**_____

(Facility requesting file form)

REQUEST FOR PATIENT FILE

Patient Name:_____ **DOB:**_____

Patient Address:_____

_____

I hereby request a copy of my patient files to be forwarded to:

SunWise Family Dermatology & Surgery

Entire File: **YES** **NO**

Specific sections (i.e.pathology, labs, cultures)

_____

_____

_____

Patient Signature: _____ **Date:** _____

Practice Representative Signature: _____ **Date:** _____