DERMATOLOGY ASSOCIATES OF CENTRAL NJ

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Freehold Skin Clinic & Cancer Center

250 South St · Freehold, NJ 07728 · Tel.: (732) 780-7870 · Fax: (732) 252-9703-9566

Medical Records Request

I,_____ DOB _____ Would like to obtain a complete copy of my medical records.

I,_____ DOB_____ Would like to ONLY obtain a copy of my pathology/blood work.

I understand that once the information is disclosed, the information is subject to re-disclosure and may no longer be protected by the federal privacy regulation.

Reason for Request_____

Signature of Patient or Patent/Guardian:_____Date:_____

Please understand that by law we have 30 days to release your records. Thank you!

I,_____DOB_____ hereby authorize the release of all my medical records or copies of such to:

Physician/Facility: _____

_____

_____

Signature of Patient or Patent/Guardian:_____Date:_____