REVISED 10/1/2018

Reply to:
- ○ Main Fax: (706) 543-2050
- ○ Nurse Fax: (706) 622-4173

MEDICAL RECORDS REQUEST/RELEASE FORM

Patient Name: ____________________________ Date of Birth: ___________ MRN: __________

INITIAL HERE ______ I authorize Georgia Skin Cancer to release information to:

OR

INITIAL HERE ______ I authorize Georgia Skin Cancer to obtain information from:

____
Entity or Name of Provider or Facility

____
Address/City/State/Zip

____
Phone Number Fax Number

To release my:

INITIAL HERE ______ Biopsy Results and Most Recent Lab Reports
INITIAL HERE ______ Dermatologic Surgical Procedures
INITIAL HERE ______ Complete Medical Record (Outgoing Records Only)

____ ___________________________
Patient Name (Print) Date (EXPIRES 1 YEAR FROM DATE ABOVE)

____
Patient Signature

If we are requesting medical records from your practice:
Please send records over 10 pages by mail.
1180 Resurgence Drive Suite 100, Watkinsville, GA 30677