REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: ____

Date of Birth: _______________________ Social Security #: ____________________

I, _________________________________ hereby request a photocopy of my medical records.

Including:

- ☐ Office Visit Notes — Dates: ___________
- ☐ Pathology Reports — Dates: ___________
- ☐ Correspondence with other physicians — Dates: __________
- ☐ Entire Record
- ☐ Other: ______________________________

To be released from the office of:

Physician's Name: ____________________________________

Address: ____

City: _________________ State: _______ Zip: _____________

Phone: ____

Please send to:

Wendy Sadoff MD Dermatology PC
31360 Northwestern Highway
Farmington Hills, MI 48334

Signature: ____