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:___________
Lab Reports Dates:___________
Correspondence w/ other physicians Dates:___________
Entire Record
Other:__________________________

To be released from:

Physician's Name:______________________________
Address:_____________________________________
City:_____________________State:______________Zip code:_______________
Phone:______________________

Please send to:

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

Phone: (248) 855-3300
Fax: (248) 855-3319

Patient Signature:________________________________Date:___________