

Southern Tier Dermatology & Aesthetics

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Request for Records

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Requesting Records From:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Requesting Records be sent to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please include the following:

\_\_\_ All Records from Date: \_\_\_\_\_ to Date: \_\_\_\_\_

\_\_\_ Lab Work from Date: \_\_\_\_\_ to Date: \_\_\_\_\_

\_\_\_ OP-Reports from Date: \_\_\_\_\_ to Date: \_\_\_\_\_

\_\_\_ X-Ray Reports from Date: \_\_\_\_\_ to Date: \_\_\_\_\_

\_\_\_ OTHER \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient a minor Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_