Michael R. Warner, M.D.
Laser and Cosmetic Dermatology
Mohs Micrographic Surgery

THE COSMETIC & SKIN SURGERY CENTER

Wyatt C. To, M.D.
Facial Plastic and Reconstructive Surgery

Medical Records Release Form

From: The Cosmetic & Skin Surgery Center
Office of Drs. Michael Warner & Wyatt To
63 Thomas Johnson Dr, Ste B
Frederick, MD 21702

Patient's Name: _____
Date of Birth: _____

Recipient: _____

A copy or summary of the following records is requested for release to the person/company stated above:

- ☐ Complete Medical Record
- ☐ Biopsy Report(s)
- ☐ Lab Report(s)
- ☐ Consultation Reports
- ☐ Medication Allergies
- ☐ Allergy Test/Treatment
- ☐ Surgical Procedures
- ☐ Other _____

For dates of service from _____ to _____

I request the records be sent in the following format (select one):

- ☐ Disc
- ☐ Flash drive
- ☐ Hard copy (paper)
- ☐ Electronic copy (email)

Send records to (select one):

- ☐ Fax Number: _____
- ☐ Address: _____
  _____
- ☐ Email: _____

You have the option to request your records be electronically mailed (emailed). However, please be advised that email communication can be intercepted in transmission or misdirected. We follow guidelines that help to minimize the risk of a breach of privacy, but they do not eliminate that risk. We recommend you consider communicating any sensitive information by telephone, fax or mail. By signing below, you acknowledge such risks should you request your records be submitted in this manner.

Reason: ☐ Transfer of care ☐ Insurance ☐ _____

_____ _____
Patient Signature Date

For Office Use Only
Notes: _____
_____
_____