

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

THE
**COSMETIC &
SKIN SURGERY**
C E N T E R

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

Medication/Allergy Record

Biopsy Report(s)

Consultation Reports

Lab Report(s)

Surgical Procedures

Other _____

For dates of service from _____ to _____

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

Disc

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 _____

I understand records may take up to 30 days to be received.

I understand that I may incur a \$0.76 fee per page per Maryland State Law for medical records to be released. This fee will not apply if sending records to another practice.

Patient Signature

Date

For Office Use Only

Notes: _____

