

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:

- | | |
|--|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Medication/Allergy Record |
| <input type="checkbox"/> Biopsy Report(s) | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Lab Report(s) | <input type="checkbox"/> Surgical Procedures |
| <input type="checkbox"/> 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 21 business 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.
- I understand a preparation fee of \$22.88 will apply if sending records to another practice.

Patient Signature

Date

For Office Use Only

Notes: _____

