Skin Solutions DERMATOLOGY

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Medical Records Release

From: Skin Solutions Dermatology PC
7 West 24th Street
New York, New York 10010

To be sent to: _____
_____
_____
_____

Patient Name: _____ Patient's Date of Birth: _____

I request a copy or summary of the following medical records:

- □ Complete Medical Record
- □ Biopsy Report(s)
- □ Lab Report(s)
- □ Consultation Reports
- □ Other

Please check one:

- □ For dates of service from ___/___/___ to ____/___/___
- □ For all dates of service

Additional Comments:

_____

I understand that there is a medical records copying fee as permissible by NY state law.

Sections 17 and 18 of Public Health Law (PHL), Laws of 1991, Chapter 165, sections 48 and 49.

- No more than $0.75 per page for paper copies
- Actual reproduction costs for radiographic materials, such as X-rays or MRI films
- Plus postage

Signature: _____ Date: _____

Relationship to patient: _____