Medical Records Release Request For ________________________________

Patient Name

From: ____________________________________________________________

To:  Christopher Ha, M.D., Roseville Dermatology
     Please fax to 916-784-7548

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

☐ Complete Medical Record
☐ Progress Notes
☐ Biopsy Report(s)
☐ Lab Report(s)
☐ Consultation Reports
☐ Medications/Allergies
☐ Allergy Test/Treatment
☐ Surgical Procedures
☐ Other __________________________________________________________

Please check one:
☐ for dates of service from __________________ to __________________
☐ for all dates of service

Additional Comments:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Patient Signature __________________________ Date ________________

For Internal Use:
Records provided on _______________ via ☐ fax ☐ mail ☐ patient