ROSEVILLE DERMATOLOGY
Medical | Surgical | Cosmetic

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American Board of Dermatology
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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