



MOY :: FINCHER :: CHIPPS  
 FACIAL PLASTICS & DERMATOLOGY

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## Medical Records Request Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I hereby authorize the release of:**

- Medical Records
- Laboratory/Pathology Results
- Photos
- Other: \_\_\_\_\_

**from Date of Service:** \_\_\_\_\_ **to** \_\_\_\_\_

**or copies of such, and request them to be transferred to**

- Self

Address: \_\_\_\_\_

Fax Number: \_\_\_\_\_

- Other Provider/Party

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\$25 Processing fee applies (Fee waived for pathology reports)**

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