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Steven Franks, M.D.

Release of Medical Records Form

Today's Date: _____

Name of Patient: _____

Date of Birth: _____

Address of Patient: _____

Phone: (home) _____ (cell) _____

Fax number where records should be faxed: _____

If requested: name/address of where records should be mailed:

(\$10 additional postal fee required)

Copies of **All** original records held by Family Dermatology, p.c. will be released, unless otherwise requested in writing. Records from referring physicians or other dermatologists/physicians will NOT be sent, unless requested.

Signature of patient or parent/legal guardian: _____

Print name of person signing and their relationship to patient if other than self:

Fee for release of records: \$25 (+ \$10 for postage if mailing)

May be paid by check (payable to "Family Dermatology, p.c."), cash, Visa, Mastercard, American Express.

Credit Card Number: _____ Exp. _____

VCode: _____ (back of card for Visa or Mastercard, front of card for American Express)

Signature of authorized cardholder: _____

Records will be released once payment has been processed. Please allow up to 15 business days for processing.