AUTHORIZATION TO REQUEST MEDICAL RECORDS

To: Provider/Group/Facility: _____

Address: _____

Telephone #: _____ Fax #: _____

Regarding Patient: _____ DOB:_____

I request and authorize that you release a copy of the following medical records to:

Andrew West,MD Nina Kahloon, MD Barbara Schrodt, MD Daniel Wendelin, MD

James Loveless, MD Lacey Vence, MD Meagan Huelsman, MD

Located at: Dermatology Associates, PSC, 2811 Klempner Way, Louisville KY 40205
Phone (502) 896-6355 Fax (502) 708-4022

- ❑ Complete Medical Record
- ❑ Biopsy Report(s)
- ❑ Lab Report(s)
- ❑ Consultation Reports
- ❑ Medication Allergies
- ❑ Allergy Test/Treatment
- ❑ Surgical Procedures
- ❑ Other _____

Please check one:

- ❑ For dates of service from ___/___/___ to ___/___/___
- ❑ For all dates of service

Additional Comments:

_____

_____

I understand that there may be a reasonable medical records copying fee as permissible by state
law.

_____ ___/___/___
Patient Signature Date