

MOY-FINCHER-CHIPPS FACIAL PLASTICS/DERMATOLOGY

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RECORDS RELEASE/REQUEST FORM

DATE: _____

I HEREBY RELEASE MY _____, OR COPIES OF SUCH, AND REQUEST
THAT THEY BE TRANSFERRED TO:

(NAME)

(ADDRESS/FAX/EMAIL)

NAME OF PATIENT: _____
(PLEASE PRINT)

SIGNATURE: _____

NOTES/SPECIAL
INSTRUCTIONS: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse (Initial): _____
Psychiatric/Mental Health (Initial): _____
Tests for Antibodies to HIV (Initial): _____
HIV Diagnosis/Treatment (Initial): _____

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