



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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