REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ Social Security #: _____

I, _____ hereby request a photocopy of my medical records.

Including:

- ☐ Office Visit Notes Dates: _____
- ☐ Pathology Reports Dates: _____
- ☐ Correspondence with other physicians Dates: _____
- ☐ Entire Record
- ☐ Other: _____

To be released from the office of:

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Please send to:

Wendy Sadoff MD Dermatology PC
31360 Northwestern Highway
Farmington Hills, MI 48334

Signature: _____