Ira L. Skolnik, M.D., Ph.D.
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Family DERMATOLOGY, p.c.

Release of Medical Records Form

Today's Date: _____
Name of Patient:_____
Date of Birth:_____
Address of Patient:_____
Phone: (home)_____ (cell)_____

Fee for release of records: $30 (If mailing: add $20 for postage + 90¢ per page for photocopying)
May be paid by check (payable to "Family Dermatology, p.c."), cash, Visa, Mastercard, American Express.

Name of person / doctor / office where records are being faxed to:_____
Fax number where records should be faxed: _____

If requested: name/address of where records should be mailed:
($20 additional postal fee required + 90¢ per page for photocopying)
_____
_____
_____

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:
_____

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.

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