EVANS
DERMATOLOGY
PARTNERS

REQUEST FOR RELEASE OF MEDICAL RECORDS

PLEASE SIGN AND THEN FAX OR MAIL THIS LETTER TO YOUR DOCTOR'S OFFICE

This letter is to request that a portion of my medical records be sent by mail or fax to Evans Dermatology Partners to be used in my treatment and ongoing care.

Doctor Providing Records

Name of Doctor: _____

Phone Number: (____) _____

Fax Number: (____) _____

Records requested: ☐ Entire Chart ☐ Recent lab results ☐ Other _____

Expiration date of request: 1/1/2015

Patient Information

Name: _____

Date of Birth: _____

Patient SSN: _____

Patient or Parent/Guardian Phone Number:

Patient Signature (if over 18): _____

If under 18, Parent or Guardian's Name: _____

Parent or Guardian's Signature: _____ Date: _____

Receiving office, please send records to: Evans Dermatology Partners
9701 Brodie Lane, Ste A-106
Austin, TX 78748

Or fax to: (512) 280-3938