PLEASE SEND THE BELOW FORM EITHER BY FAX TO NUMBER 1-888-573-0231, BY EMAIL TO ADDRESS Contact@lawrenceburgderm.com (*Please be advised that email is not a secure method and by submitting a request via this method you are assuming all risks.*) OR BY MAIL TO FirstCare Dermatology of Lawrenceburg, PLLC c/o Records Administration PO BOX 947977 Atlanta, GA 30394-7977

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____
PATIENT PHONE NUMBER: _____

Dear FirstCare Dermatology of Lawrenceburg Records Department:

Please release a copy of all of my health information that the practice has in its possession as directed below. I understand the information to be released or disclosed may include information relating to any medical history, mental or physical condition and any treatment received by me, including (to the extent applicable) any HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records:

Please check one:

1. ___ MAIL (Please provide the address below)

   _____
   _____

2. ___ FAX (Please include a working fax number and applicable "attention to:" information

   _____
   Fax Number

   _____
   Attention to

3. ____EMAIL (**Please be advised that email is not a secure method to send confidential information and by checking this box you are assuming all risk associated with sending medical records through email)**

   email address:_____

Thank you,

_____
Signature of patient or legally authorized representative

_____ _____
Print Name Date