YAG-HOWARD
DERMATOLOGY & AESTHETIC CENTER

Medical Records Release Request

*Please **give a copy** of my records to either*
☐ *Me or* ☐ *the Provider named below:*

EMAIL– MAIL – FAX my records to:	
Name	
Address	
Apt / Suite	
City, State & Zip	
Email	
Fax	
Phone	

☐ ***Most Recent*** – we will send the most recent Visit Notes, Pathology, Biopsy, Lab reports up to 20 pages at no charge.

☐ ***Other*** – after the first 20 pages:_____
The first 20 pages of your records are provided at No Charge.
Each page after is charged at $0.50/page and is to be paid in advance.
https://www.hhs.gov/hipaa/for-individuals/medical-records/index.html

My signature below is ***my Consent*** for Yag-Howard Dermatology and Aesthetic Center to release these records to the me or the Provider named above.

_____ _____
Printed Name Date of Birth

_____ _____
Signature Date