7995 66th St N. Pinellas Park, FL 33781 **Ph**: 727.530.0920 **Fax:** 727.827.7139 www.mahoneydermatology.com

TO: _____

FAX: _____

I REQUEST A COPY OR SUMMARY OF THE FOLLOWING MEDICAL RECORDS:

- ❑ COMPLETE MEDICAL RECORD
- ❑ BIOPSY REPORT(S)
- ❑ LAB REPORT(S)
- ❑ CONSULTATION REPORTS
- ❑ MEDICATION ALLERGIES
- ❑ ALLERGY TEST/TREATMENT
- ❑ SURGICAL PROCEDURES
- ❑ OTHER _____

PLEASE CHECK ONE:

- ❑ FOR DATES OF SERVICE FROM ___/___/___ TO ___/___/___
- ❑ FOR ALL DATES OF SERVICE

ADDITIONAL COMMENTS: _____

_____

I UNDERSTAND THAT THERE MAY BE A REASONABLE MEDICAL RECORDS COPYING FEE AS PERMISSIBLE BY STATE LAW

_____ ___/___/___

PRINTED PATIENT NAME D.O.B.

_____ ___/___/___

PATIENT OR GUARDIAN SIGNATURE DATE