# Brian J. Williams, M.D., P.C.

D E R M A T O L O G Y

Board Certified

## REQUEST FOR RECORD RELEASE

**Name of Patient:**_____ **Date of Birth:**_____

Social Security Number:_____ Home Phone:_____

Address:_____ Work Phone:_____

City, State, Zip:_____ Fax #:_____

**I HEREBY AUTHORIZE (Where records are being requested from):**

_____

Address: _____

_____

Phone #: _____ Fax #:_____

**TO RELEASE MY RECORDS TO (Where records need to be sent):**

_____

Address:_____

_____

Phone #:_____ Fax #:_____

**Date records are needed by:**_____

**THIS RECORD RELEASE IS VALID FOR 90 DAYS ONLY: Most requests will be processed in 5-7 business days.**
**I understand all copying fees will be billed to my account and that I am responsible for payment.**

**PATIENT'S SIGNATURE:**_____ **Date:**_____

**PLEASE CHECK ONE**

- ☐ Last five years
- ☐ Records concerning:_____
- ☐ Records from date(s) of service:_____
- ☐ Labs (For dates of service)_____
- ☐ Other:_____

| OFFICE USE |
|---|
| Date mailed:_____ |
| Date faxed:_____ |
| Date picked up:_____ |
| Sent by: |

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