Fax Number: 678-582-8925
Email: medicalrecords@mariettaderm.com
111 Marble Mill Rd. NW Marietta Ga 30060
130 Oakside Ct. Canton, Ga 30114
5041 Dallas Hwy Ste D, Powder Spring, Ga 30127

MARIETTA DERMATOLOGY & THE SKIN CANCER CENTER

# Medical Record Release Form

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

***CHECK ONLY ONE***

____ Release to SELF (fees for records are below)

____ Requesting transfer ***TO*** Marietta Dermatology from the office listed below

____ Requesting transfer ***FROM*** Marietta Dermatology to the office listed below

Provider/Office Name: _____

Office Phone Number: _____ Office Fax Number: _____

Address: _____

*Must complete forwarding address & fax number in full or form is void and unable to send requested information.*

I am requesting a copy or summary of the following medical records: *(check all that apply)*

___ Complete Medical Record ___ Mohs Procedure(s)

___ Pathology Reports ___Surgical Procedures

___ New Patient Consultation (***Only***) ___Services provided from _____ - _____

(If nothing checked, the request is incomplete and voided)

*I hereby authorize Marietta Dermatology to release and or accept medical information as requested above. I am aware that Marietta Dermatology cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Marietta Dermatology may or may not protect this information once it has been disclosed to the recipient. Furthermore, I understand that the medical records released may contain my confidential health related information and my signature confirms my approval and understanding.*

*This authorization expires 90 days from the signature date. Copy associated with this request are listed below. I can cancel this authorization in writing at any time. Georgia Medical Records Retention Statute GA. Code Ann. SS 31-33-2(a)(1)(B)(i) no records are required to be kept ten years from the date of creation. If the form is incomplete, is it void and request will not be fulfilled.*

_____ _____

**Patient or Legal Guardian Signature** **Date**

***Form must be filled out in its entirety for processing.*** *Requests over 50 pages will be e - mailed or mailed. Pursuant to Statute 31.33.3 the actual cost of postage incurred will be charged along with a fee of $0.25 per page requested. If this is an urgent request and you are unable to wait for traditional mail, please use our Patient Portal located on our website. www.mariettaderm.com*