DERMATOLOGY ASSOCIATES of GEORGIA

Medical Records Request

Patient Name: _____ DOB: _____

Request From: _____

_____

_____

Please Send To:

Decatur
1951 Clairmont Road
Decatur, GA 30033
404-321-4600 • Fax 404-320-0987

Johns Creek
4285 Johns Creek Parkway
Suite A
Suwanee, GA 30024
770-622-4412 • Fax 770-622-4191

DeKalb Medical Center
2665 North Decatur Road
Suite 650
Decatur, GA 30033
404-508-0566 • Fax 404-508-0567

Piedmont
2061 Peachtree Road
Suite 400
Atlanta, GA 30309
404-554-0810 • Fax 404-554-0348

Monroe
201 Michael Etchison Road
Monroe, GA 30655
770-267-5877 • Fax 770-207-4944

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 _____

for dates of service from _____ to _____

Additional Comments: _____

_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Witness Date

Request expires one year from date completed