



Medical Records Request

Patient Name: _____

Request From: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dermatology Associates of Georgia, L.L.C

Decatur Office

1951 Clairmont Road
Decatur, GA 30033
Phone: (404) 321-4600
Fax: (404) 320-0987

Johns Creek

4285 Johns Creek Parkway
Suite A
Suwanee, GA 30024
Phone: (770) 622-4412
Fax: (770) 622-4191

Monroe Office

201 Michael Etchinson
Rd.
Monroe, GA 30655
Phone: (770) 267-5877
Fax: (770) 207-4944

Peachtree Corners Professional Center

5635 Peachtree Parkway
Suite 270
Norcross, GA 30092
Phone: (678) 728-1500
Fax: (678) 728-1519

I request a copy or summary of the following medical records:

- Complete Medical Record
- Medication Allergies
- Biopsy Report(s)
- Allergy Test/Treatment
- Lab Report(s)
- Surgical Procedures
- Consultation Reports
- Other: _____

For dates of service from Start Date: _____ to End Date: _____

Additional Comments:

PRINT NAME

Patient Signature

Date Signed

PRINT NAME

Witness

Date Signed

Request expires one year from date completed