



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

Dekalb Medical Office

2665 N. Decatur Road
Suite 650
Decatur, GA 30033
Phone: (404) 508-0566
Fax: (404) 508-0567

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

- | | |
|--|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Medication Allergies |
| <input type="checkbox"/> Biopsy Report(s) | <input type="checkbox"/> Allergy Test/Treatment |
| <input type="checkbox"/> Lab Report(s) | <input type="checkbox"/> Surgical Procedures |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Other: _____ |

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

Additional Comments:

WITH NAME

Patient Signature

Date Signed

WITH NAME

Witness

Date Signed

Request expires one year from date completed