

**CAPE COD DERMATOLOGY, LLC
134 ANSEL HALLET RD
WEST YARMOUTH, MA 02675
508-771-9779 – FAX:508-771-4355**

Please fill out and sign the below form and then fax it to 508-771-4355 or mail it to the above address. We are not able to accept records requests via email. Thank you.

RECORDS RELEASE FORM

TO: Cape Cod Dermatology, LLC

DATE: _____

PATIENT: _____

DATE OF BIRTH: _____

**I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE
COPIES OF MY MEDICAL RECORDS CONCERNING MY ILLNESS
AND/OR TREATMENT TO:**

**IF THERE ARE SPECIFIC CATEGORIES IN YOUR MEDICAL RECORD
YOU DO NOT WANT RELEASED..... PLEASE INDICATE:**

SIGNED: _____ **DATE:** _____