MEDICAL RECORDS RELEASE

I, _____ / _____, request that
(Print **Patient's Name**) (**Date of birth**)

Dr. Daniella Duke
Coastal Dermatology, P.C.
55 Willow Street
Mystic, CT 06355 FAX: (860) 245-0610 Phone: (860) 245-0000

Release a copy of my medical records to:

_____ ** (____)_____
Name of Doctor or Facility Holding the Record **FAX number of New Doctor**

_____
Address of Doctor or Facility Holding the Record City/Town State Zip Code

_____ _____
Signature of Patient (or Guardian) **Date**

Mail (or deliver) this completed and signed request to:
Records Transfer Request
Coastal Dermatology, P.C.
55 Willow Street
Mystic, CT 06355

or fax it to Dr. Duke's office at: (860) 245-0610

**** If we *fax* your records to your new Provider (or to you), then there is no fee.**
