

Southern Dermatology, LLC  
2110 Woodside Executive Court  
Aiken, S.C. 29803  
803.644.8900

Date: \_\_\_\_\_

To Whom It May Concern:

You have requested a copy of the medical records pertaining to your treatment. According to the S.C. Physicians' Patient Records Act, Section 44-115-80 the following fee\* may be charged for duplicating and transferring your records. Should this fee be applicable, you will be notified of the amount by the appropriate party after the records are assessed. The records will then be mailed according to the directive given on this form.

You may view a copy of this statute online at: [www.llr.state.sc.us/me.htm](http://www.llr.state.sc.us/me.htm)

Request for medical records to be released:

I, \_\_\_\_\_ request the release and transfer of my medical record to be mailed in full or as specified below from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I further request that the transfer of the medical records be sent to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Should there be any questions about this transfer you may contact me at the following numbers.

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

*Clerical Fee of \$15.00:	<u>\$15.00</u>
First 30 pages @ \$.65 per page	_____
Additional pages @ \$.50 per page	_____
Actual Postage:	_____
Total Amount Due:	_____