GOLDMAN DERMATOLOGY, PLLC
150 Broadway, Suite 1110
New York, NY 10038

ACCESS REQUEST FORM

Individual's Name: _____
Last First Middle

Home Address: _____

_____

Home Phone: _____ Date of Birth: _____

I hereby request that the Practice provide me with access to a copy of my lab/biopsy/patch test results. Please provide the requested information to me in [please check the appropriate line] ___ pick-up at the office or ___ have a copy of the requested information mailed or faxed to the following:

_____

_____

_____

_____ _____
Signature of Patient (or Personal Representative) Date

_____ _____
Printed name of Patient or Personal Representative Relationship to Patient