

Main Office Princeton:

208 Bunn Drive Princeton, NJ 08540 Office: 609-683-4999 Fax: 609-683-0298

North Brunswick Office:

1950 State Highway 27 Suite A

North Brunswick, NJ 08902

Office: 732-297-8866 Fax: 732-821-0626

Monroe Office:

5 Centre Drive Suite 1A Monroe Twp., NJ 08831

Office: 609-655-4544 Fax: 609-655-2390

Hillsborough Office:

307 Omni Drive Hillsborough, NJ 08844 Office: 908-281-6633 Fax: 908-281-6690

Central Billing Office:

Office: 609-683-8224 Fax: 609-683-8222

Princeton Dermatology Associates PC Dermatology and Dermatologic Surgery

How to obtain copies of your Medical Records

To request a copy of your medical records, please complete the authorization form. This form can be downloaded from our website. You may return the completed signed form in person, by fax or mail to our office.

Copies of medical records can only be released to the patient, his/her authorized representative or healthcare provider. If you would like someone to pick up your records, you must indicate on the form the first and last name of the person picking up the records. A proof of ID will be required.

Please allow at least 10-14 business days for processing.

Charges for Medical Records Requests

Per New Jersey State Law, patient medical record copies are \$10.00 minimum and \$1.00 per page. Charges are not to exceed \$100.00 for the entire record.

Once your request is received, we will contact you and let you know the amount due for your records to be copied.

Should your records need to be sent to another healthcare provider, the most recent records or biopsy reports will be sent free of charge.

Payment can be made by check or cash only. Checks are to be made payable to:

Roderick Kaufmann, MD

Patient Portal

Medical records may also be obtained from our secure Patient Portal where they can be printed or downloaded free of charge. Please contact our office for access to your portal.

Princeton Dermatology Associates, PC Dermatology and Dermatologic Surgery

208 Bunn Drive, Princeton, NJ 08540 Phone (609) 683-4999 Fax (609) 683-8222

Medical Records Release Form

Patient Nam	ne	
Date of Birtl	h	
I,Please print your name Patient's medical records to: (Name		, hereby request that you release a copy of me, address and/or fax number)
Please sen	d the following record	l(s):
	Complete record	Biopsy/Pathology results
	Blood work	Chart note
Date(s):	to	·
Date	of Request	Patient / Authorized Person Signature