Princeton Dermatology Associates PC
Dermatology and Dermatologic Surgery

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

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

Medical Records Release Form

Patient Name _____

Date of Birth _____

I, _____, hereby request that you release a copy of
Please print your name
Patient's medical records to: (Name, address and/or fax number)

_____

_____

_____

_____

Please send the following record(s):

_____ Complete record _____ Biopsy/Pathology results

_____ Blood work _____ Chart note

Date(s): _____ to _____.

_____ _____
Date of Request Patient / Authorized Person Signature