Dermatology & Allergy Specialists of Virginia

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PRINT Patient Full Name _____ Birth Date (Month/Day/Year) _____

Street Address _____ SSN (last 4 digits) _____

City, State, Zip Code _____ Phone (Home) _____

At the request of the individual, I _____, (Patient Name or Parent Name) do hereby authorize Dermatology & Allergy Specialists to release:

RECORDS ARE REQUESTED FOR THE FOLLOWING DATES/TIME PERIODS: _____

___ MOHS NOTES
___ CANCER PATHOLOGY REPORTS
___ SURGICAL PATHOLOGY

___ LAST 2 YEARS
___ ALL RECORDS
___ OTHER _____

INFORMATION RELEASE TO:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE:

___ REFERRAL TO SPECIALIST
___ OTHER _____

___ PERSONAL

Please provide current telephone number: (____) _____

This release is effective for 1 year from the date of the execution; however, I may revoke it at any time by providing notice in writing to the above named party. I hereby acknowledge receiving a completed copy of this release and that a copy of this form is acceptable authorization for the release of the above described information. I understand that except for certain research purposes, the completion of this authorization is not required prior to the provision of treatment. I understand that the information released pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.

_____ _____
Signature of the individual, guardian or Personal Representative of patient estate (Power of Attorney must be on file with the office or accompanying this request.)

Date

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. Virginia State Rates apply as pages 1-50 at $0.50 per page, pages +51 at $0.20 per page, plus first class postage. RECORDS WILL BE MAILED ONCE PAYMENT HAS BEEN RECEIVED.