ARLINGTON DERMATOLOGY

Authorization for Release of Medical Information

Patient:_____ Date:_____

Address: _____ DOB:_____

City/State/Zip:_____ Phone: __(____)_____

I authorize Arlington Dermatology PLLC to:

___ Send copies of your record to (or discuss information with) the provider/person/facility below

OR

___ Receive copies of your record from (or discuss your information with) the provider/person/facility below.

Name of Provider/Person/Facility: _____

Address: _____

City/State/Zip: _____

Phone: __(____)_____ Fax: __(____)_____

Information to be disclosed:

_____Progress Notes

_____ Pathology/Lab Report(s)

_____Operative Notes

_____ Cosmetic Notes

_____Entire Medical Information

Start Date of Information to be disclosed: _____

End Date of Information to be disclosed: _____

Record Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. There may be a charge for the requested records according to VA State Law. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request to Arlington Dermatology PLLC. I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. Patient/Representative:

Signature: _____Date: _____

Parent/Guardian signature required for minor (less than 18 years of age):

Relationship to patient (if other than self): _____

Printed name of Authorized Representative: _____