



# RICHMOND DERMATOLOGY

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## MEDICAL RECORDS RELEASE

### PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTHCARE INFORMATION

**Patient Name:** \_\_\_\_\_ **Date/Birth** \_\_\_\_\_

**Previous name, if applicable:** \_\_\_\_\_

I request and authorize \_\_\_\_\_

PLEASE PRINT NAME OF PHYSICIAN OR MEDICAL PRACTICE

**to release healthcare information of the patient named above to:**

NAME OF THE INDIVIDUAL OR ENTITY TO RECEIVE THE INFORMATION

ADDRESS

CITY

STATE

ZIP CODE

This authorization applies to:  All healthcare information **OR**  Specific healthcare information  
(Specific: list dates, treatment and/or condition – please specify below)

\_\_\_\_\_  
\_\_\_\_\_

I understand that once this information is released by Richmond Dermatology Specialists, PC, the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

This authorization will expire 90 days after it has been signed.

\_\_\_\_\_  
**Signature of Patient, OR Parent/Legal Guardian** **DATE**

\_\_\_\_\_  
**Print the name of the Parent/Legal Guardian executing this authorization.**

\_\_\_\_\_ Scanned into chart  
Initials