Richmond Dermatology & Laser Specialists
9816 Mayland Drive
Richmond, VA 23233
(804) 282-8510 FAX (804) 285-5750

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 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