Richmond Dermatology
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 of Birth** _____

Previous name, if applicable: _____

I request and authorize _____
PLEASE PRINT NAME OF PHYSICIAN OR MEDICAL PRACTICE RELEASING THE INFORMATION

_____
ADDRESS **CITY** **STATE** **ZIP**

(_____)_____(_____)_____
PHONE NUMBER **FAX NUMBER**

To release healthcare information of the patient named above to:

_____
NAME OF THE INDIVIDUAL OR ENTITY TO RECEIVE THE INFORMATION

_____
ADDRESS **CITY** **STATE** **ZIP**

(_____)_____(_____)_____
PHONE NUMBER **FAX NUMBER**

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 Specialist, 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**

**Please allow 7-10 business days after returning this completed form for records to be released. **