VIRGINIAdermatology
& skin cancer center

Phone (757)455-5009 fax: (757) 362-3577

MEDICAL RECORDS RELEASE FORM

Patient Name: ____________________
Date of Birth: ____________________
SSN#: ____________________
Phone Number: ____________________

I hereby authorize Virginia Dermatology and Skin Cancer Center to

□Release the following information contained in my medical records.
From Virginia Dermatology and Skin Cancer Center
Please release/ mail to attached address:

____
____
____

□Receive the following information contained in my medical records.
Physician Name: ____________________
Phone Number: ____________________
Fax Number: ____________________

This includes:
□ All medical records □Date From__________-To__________
□ Only specific dates regarding ______________________.

This is □ A one time disclosure □ A continuing disclosure for 12 months

I understand that I may revoke this authorization in writing at any time, except to the extent that release had been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breech of my right to confidentiality.
Unless I otherwise revoke this authorization in writing it shall expire on the following date , event, or condition: ______________________________.
At that time no express revocation shall be needed to terminate my authorization. I hereby release Virginia Dermatology and Skin Cancer Center from any legal responsibility or liability for disclosures that may arise as a result of the use of the information contained in the PHI (Personal Health Information) released.

X______________________________ ______________________
Signature of Patient (or Legal Representative) **Date**