Dermatology Associates of Virginia, P.C.

Patient Authorization for REQUEST or RELEASE of Medical Records

Patient Name: ____ DOB: __________________

Address: ____

Email: ____

I authorize Dermatology Associates of Virginia to OBTAIN FROM or RELEASE TO protected health information about me.

OBTAIN FROM:	RELEASE TO:
________________________________	________________________________
Name	Name
________________________________	________________________________
Address	Address
________________________________	________________________________
City State Zip	City State Zip

Release/Obtain the following individually identifiable health information about me: (Indicate dates of service)

□ Office Notes ____________ □ Lab Work____________ □ Pathology Reports ____________

□ Complete Record ____________ □ Other ____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer, Rachel Downey at: Dermatology Associates of Virginia, 201 Concourse Blvd., Suite 200, Glen Allen, VA 23059.

Signed by: _______________________ ______________________________________

Signature of Patient or Legal Guardian Relationship to Patient

Date: ___________________________

*****Note: The entity you are requesting records from may charge you a fee to release these records*****

Patients requesting medical records sent directly to them electronically will be charged $0.37 per page for the first 50 pages and $0.18 per page for the remaining pages.

Patients requesting medical records sent directly to them on paper will be charged $0.50 per page for the first 50 pages and $0.25 per page for the remaining pages, and the cost of postage.

Office Use only - Chart #: __________________________