



COMMONWEALTH DERMATOLOGY, P.C.

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Authorization to Release Records to Commonwealth Dermatology

Patient Name: _____ Date of Birth: ____/____/____

Address: _____

City, State, Zip _____ Phone (____) _____

I hereby request that the following Doctor/ Medical Practice release the requested information to Commonwealth Dermatology:

Name of Dr./Practice to send records: _____

Address: _____

City, State, Zip: _____

Ph: (____) _____

Fax:(____) _____

Please send the following information:

- Entire Records
Office Visit Notes
Biopsy Reports
Blood Work
Radiology Reports
Financial Records
Other:
Approximate Dates of Service:

Send Records to:
Commonwealth Dermatology:
7001 Forest Ave. Suite #400
Henrico, VA 23230
Fax# (804) 288-7135

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
I may inspect or copy the protected health information to be disclosed as described in this document.
Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date _____

Signature of Patient or Personal Representative

Relationship of Personal Representative's Authority _____