



Laurie Shinn, M.D.
Hazel Vernon, M.D. (Urgent Clinic)
Sarah Skillman, M.D.
Lori Darrah, NP
Samantha Martin, NP
Sarah Burchett, PA-C

Camille Royster, M.D.
Matthew Sage, M.D.
Ana Wiley, NP
Amanda Shull, NP
Mary Graves, PA-C

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

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 _____