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
_____ Phone	_____ Phone
_____ Fax	_____ Fax

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, 7201 Glen Forest Drive, Suite 100, Richmond, VA 23226.

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 #: _____