"Comprehensive Family Skin Care"
• Medical • Surgical • Cosmetic

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PERMISSION TO RELEASE MEDICAL RECORDS

Patient's Name: ________________________ **Date of Birth:** ________________

Address, City, State, Zip: ____

As a patient, or parent/guardian of a patient, of Arlington Center for Dermatology, I authorize this office to release the following medical records for myself or my child to the following recipient:

Name of recipient: ____

Address: ____

Phone: ________________________ **Fax**: ____________________________

Reason for release: ____

This request and authorization applies to: (check the appropriate line)

___Clinical Visit Notes ___Pathology Reports ___Lab Reports ___Billing records

___ All medical records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

Dates of service requested: _______________ to _______________

_________________________________ _________________________

Signature of Patient or Legal Representative **Date**

_________________________________ _________________________

Printed Name **Relationship to Patient**

I understand that I have the right to revoke this authorization by providing a written request to Arlington Center for Dermatology. I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked this authorization will expire one year from the date signed. I understand that authorizing disclosure of this health information is voluntary and any disclosure of information carries the risk for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.