7813 Shrader Road Henrico, Va 23294
Phone: 804-264-4545 Fax: 804-264-4260

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _______________________________________Date of Birth: _____________________

I hereby **AUTHORIZE** and give consent to:

Name: ____

Address: ____

City, State, Zip Code: ____

Phone: ___________________________________Fax: _______________________________________

To **RELEASE** healthcare information on the above named patient **TO:**

Name: ____

Address: ____

City, State, Zip Code: ____

Phone: _______________________________________ Fax: ____

This request and authorization applies to the following: (Check one)

( ) No Limitations
( ) The following dates only: __________________________to ___________________________
( ) Other ____

And for the following reason or purpose:

( ) Continued medical care
( ) Other (Specify) ____

This authorization to release confidential information may be revoked by me in writing at any time, except to the extent that the action has taken in reliance on it. It shall be effective only long enough to fulfill the specific purpose for which it is given or for sixty days, whichever comes first. No further confidential information will be released without the execution of an additional written statement of consent. I understand that I am not required to give this consent, and that I can refuse without any prejudice to my future treatment at Affiliated Dermatologists of Virginia.

____ ____________________________________

Signature of Patient/Parent/Authorized Representative Date of Consent