The Clinical Skin Center of Northern Virginia, PLLC

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Best phone number to reach you:** _____

I Authorize the Release of my Medical Records to:

Name of Recipient: _____

Address: _____

Email: _____ **Phone:** _____

Fax: _____

Please select how you would like us to send your records:

○ Email ○ Fax ○ Mail ○ Pick Up

I request a copy of the following medical records:

☐ Complete Medical Records ☐ Biopsy Report(s) ☐ Lab Reports(s)

Other: _____

Dates of service for requested records:

☐ **All Dates** OR Choose Dates: **From:** _____ **To:** _____

Signature of Patient or Responsible Party (signed electronically): _____ **Date:** _____

Signature may be confirmed with copy of photo ID

Office Use Only

Date: **Time:** **Initials:**

☐ **Picked Up** ☐ **Faxed** ☐ **Mailed** ☐ **Emailed**