

Affiliated Dermatologists of Virginia
7813 Shrader Road
Richmond, Virginia 23228

AUTHORIZATION FOR RELEASE OF INFORMATION

(Please complete all sections)

I, _____ (NAME OF PATIENT) _____ (DATE OF BIRTH)

Hereby authorize and give to consent to _____
(Name and address of person or agency to _____
RELEASE the information) _____

and limited to the following specific items (CHECK ONE)

- No limitations
- The following dates only: _____ to _____
- Other: _____

permit the confidential information to be released only to the following person, agency or organization. (Name and address _____
of person or agency to _____
RECEIVE information) _____

I permit this confidential information to be release only for the following reason or purpose: (CHECK ONE)
 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 action has been 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, which ever is sooner. 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 Dermatologist of Virginia.

(Date of Consent) Signature of Patient/Parent /Authorized Representative

If signed by person other than patient, please state relationship to patient:

If signed by authorized representative, state why patient is unable to sign:
