



## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I **AUTHORIZE** Premier Dermatology, P.C. to  **RELEASE** or  **RECEIVE** the medical information  
 **TO** or  **FROM**:

Name of receiving person/organization \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Release Records Dating from: \_\_\_\_\_ TO \_\_\_\_\_

Purpose or need for disclosure:

- Continued Medical Care     Payment of Insurance Claim     Legal  
 Worker's Compensation Claim     Personal     Other: \_\_\_\_\_

**I UNDERSTAND** that I (or the person authorized to act on my behalf) am entitled to receive a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for a duplication of records. An estimate of charges will be provided upon request prior to duplication.

**I UNDERSTAND** that I may revoke this authorization at any time (in writing) except to the extent that action has been taken in reliance on it. To revoke this authorization, please provide a written statement to Premier Dermatology, P.C.

**I AM AUTHORIZING** and directing Premier Dermatology, P.C. to release/receive my medical records which may include information regarding alcohol, drugs, mental health, sexually transmitted diseases, HIV, AIDS. I understand that this authorization will automatically expire twelve months from the date signed.

Patient's Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Present Mailing Address: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Patient/Legal Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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