



• 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.