

DERMATOLOGY ASSOCIATES, INC.

Main Office Location ♦ 1514 Amherst Street, Winchester VA 22601 ♦ Phone No. 540-667-4499 ♦ Fax No. 540-722-4172

REQUEST FOR RELEASE OF INFORMATION AND DISPENSING INFORMATION RECORD**Please print unless signature is required****Person/Facility Requesting Information:** _____ **Date Needed:** _____
Signature/Print Name Date / /**Requesting Release of the Records of**Dermatology Assoc.
MRN: _____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Address: _____
Street City State Zip

Day Time Phone Number: _____ Cell Phone Number: _____

Information to be released FROM (select one)

- ☐
- Dermatology Associates, Inc. – main office located at 1514 Amherst Street, Winchester VA 22601
-
- ☐
- Other Organization, Physician, or provider (please list) _____

Address: _____
Street City State Zip

Office Phone Number: _____ Fax Number: _____

Information to be released TO: (select one)☐ **SELF**

- ☐
- Dermatology Associates, Inc. – main office located at 1514 Amherst Street, Winchester VA 22601
- Fax: 540-722-4172 Phone: 540-667-4499**
-
- ☐
- Other Organization, Physician, or provider (please list) _____

Address: _____
Street City State Zip

Office Phone Number: _____ Fax Number: _____

Purpose of Release

- ☐
- Legal
- ☐
- Insurance
- ☐
- Doctor
- ☐
- Medical Leave
- ☐
- Copies for personal use
- ☐
- Other _____

What kind of information do you want released?

- ☐
- Copies of Records (faxed, mailed, emailed, or picked up by patient)
- ☐
- Verbal Communication to specific person listed above
-
- ☐
- Medical records requested for date range:
- ☐
- All
- ☐
- Specific From _____ / _____ / _____ To _____ / _____ / _____
-
- ☐
- Specific Information (illness, disease, or condition): _____
-
- ☐
- Billing records (specify date of service) _____
-
- ☐
- Pathology Reports (specify area/date of service) _____

Patient/representative must initial as
consent to disclose this information: _____Alcohol/drug treatment _____Sexually transmitted disease _____Mental health information**REQUESTOR IS LISTED ON SIGNED HIPAA (CIRCLE ONE)****YES****NO****If NO is circled– STOP** – you cannot dispense information. Please notify requestor that a Request for Release of Information Form must be signed by patient/legal representative naming you as a person that can receive health care information before you can proceed.**If YES is circled continue** completing this form and proceed with providing the information that has been documented as being approved for release by the signed HIPAA Form and/or the signed Request for Release of Information Form. These signed documents dictate what information can be dispensed. If requestor is asking for information not approved by the patient notify the requestor that the patient will need to sign another Request for Release of Information Form specifying the information that Dermatology Associates, Inc. can release to the requestor.This authorization for release of information covers the effective period of
healthcare from this date forward unless I revoke the authorization in writing.

Signature: _____

Signature - if not patient indicate by circling the relationship - -patient, parent, guardian, authorized representative

Date

If Representative- print your name and state relationship to patient. _____

Information sent: Date: _____ / _____ / _____ Time: _____ : _____ am / pm Sent by: _____

Information sent via ☐ Fax ☐ E-Mail ☐ Standard Mail ☐ Patient pickup ☐ Other: _____**FAX TO 540-722-4172**