McLEAN DERMATOLOGY & skincare center

Authorization for the Release of Medical Record Information from McLean Dermatology & Skincare Center

Patient Full Name (If name has changed, please specify.)	Date of Birth
Street Address	City/State/Zip
Home Phone	Cell Phone

The above patient or his or her parent/legal guardian authorizes McLean Dermatology and Skincare Center, located at 6849 Old Dominion Drive, Suite 340, McLean, Virginia 22101, to make a disclosure of medical record information to the following individual or facility:

Name of Individual or Organization to which McLean Dermatology will release records:	
Street Address	City/State/Zip
Phone Number	Fax Number
Type of Information to Disclose: (Check all that apply) ☐ Entire Record ☐ Pathology Results only ☐ Blood Test Results only ☐ Culture Test Results only ☐ Receipts and billing information only ☐ Specific Visit Notes and/or Test Results _____ Visit Date(s) for Information Requested: _____	The Purpose of this Disclosure is: (Check all that apply) ☐ Change of Insurance or Physician ☐ Continuation of Care ☐ Referral ☐ Personal Records ☐ Other: _____ ☐ **Check if you would like records mailed** ☐ **Check if you would like records faxed**

Restrictions: Only medical records originated through McLean Dermatology & Skincare Center will be copied and disclosed unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date of this authorization unless other dates are specified.

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure (McLean Dermatology & Skincare Center).

I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I understand copy fees may apply.

Signature of Patient	Date
Signature of Parent/Guardian or Authorized Representative	Date
Printed Name of Parent, Guardian or Authorized Representative	Relationship to Patient (Representatives: Attach proof of such status)
Address of Authorized Representative or Guardian	Telephone Number