Access Dermatology & Spa

Medical and Cosmetic Skin Care

Convenient, Comprehensive and Accessible

563-A Neff Avenue,
Harrisonburg, VA 22801
Phone: 540-434-1756
Fax: 540-434-1840

MEDICAL RECORDS RELEASE OF INFORMATION REQUEST

Patient Name: _____

Previous Name: _____

Address: _____

City, State & Zip Code: _____

Date of Birth: _____

Social Security #: _____

Phone #: _____

I,_____ authorize Access Dermatology to release information concerning the patient identified above in accordance with state and federal laws, to: _____
Phone #: _____ Fax#:_____
By signing below, I further certify that I understand email copies and flash drives are not encrypted and may not be secure. I understand that I am responsible for providing a correct fax number or email address. I understand that printed copies belong to me, and Acces Dermatology, P.C. is no longer responsible for the privacy of copies I take once they leave the office (to inculde in transit to the post office or while in the mail). I accept responsibility for securing my private medical information whether it is received in printed or electronic forms.

_____ _____
Patient or Legal Representative's Signature Date

_____
Patient name printed

_____
Witnessed by

I request the medical records in the following format:

Please initial beside what format you would like the records to be sent.

_____ Fax to my doctor (no fee)

_____ Printed copy ($0.10 per page over 10 plus $5 for certified mail, if requested)

_____ Printed copy (no fee) if picked up in office

_____ Flash drive ($10 fee)

_____ Patient Portal (no fee)
Email address to send Portal info to
_____