P: 757-622-6315
F: 757-622-7022
pariserderm.com

Return Fax: (757) 313-5812

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, (**Name**)____, (**Date of Birth**)________________________, understand Pariser Dermatology Specialists, Ltd. is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize Pariser Dermatology Specialists, Ltd., to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I understand I retain the right to revoke this authorization and the right to inspect or copy the information to be disclosed. I may refuse to sign the authorization.

Description of the information to be used or disclosed:

[ ] The patients entire medical record
[ ] Patients most recent office visit
[ ] Pathology reports
[ ] Labs
[ ] Photographs___________________________________
[ ] Other:____

Pariser Dermatology Specialists, Ltd., may disclose/discuss my protected health information to/with:

Name: ______________________________ **Relationship to Patient:**_____________________
Name: ______________________________ **Relationship to Patient:**_____________________

This authorization permits Pariser Dermatology Specialists, Ltd., **to send protected health information ONLY to:**

Name/Physician/Practice: ____

Street Address:____

City/State/Zip:____

Fax Number:____

This authorization will expire (if no expiration date is indicated this authorization will be valid for one year from the date on this authorization):

[ ] Indefinitely
[ ] One year from the date on this authorization
[ ] Other____

After this date, PARISER DERMATOLOGY SPECIALISTS, LTD. can no longer disclose my protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of the Patient Authorization for Release of Medical Records.

____________________________________ ___________________
Patient's/Patient's Representative Signature Date

6160 Kempsville Circle, Suite 200 A, Norfolk, VA 23502
11842 Rock Landing Drive, Suite 120, Newport News, VA 23606
1248 Perimeter Parkway, Suite 482, Virginia Beach, VA 23454
207 Bulifants Boulevard, Suite C, Williamsburg, VA 23188
3907 Bridge Road, Suite 200, Suffolk, VA. 23435
510 Independence Parkway, Suite 600 Chesapeake, VA 23320