Associates in Dermatology, Inc.
Providing care to Hampton Roads since 1970

(CONSENT TO EMAIL) MEDICAL RECORDS REQUEST

Patient's Last Name _____ First _____ Middle Initial _____

Social Security # _____ - _____ - _____ Date of Birth _____ Phone # _____

Home Address _____ City, State, Zip _____

I authorize Associates in Dermatology to send/receive:

☐ Obtain Information From: ☐ Release Information To:
(INCLUDING DRUG AND/OR ALCOHOL RECORDS; HIV TESTING RESULTS,

Email Address Records to be sent: *(**see disclosure below)*:_____

Name of Individual/ Physician/Facility _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Reason for request:

☐ Transferring to a new physician ☐ Records requested by specialist ☐ Other (please specify) _____

☐ Moving out of the area (new address) _____

Information to be provided:

☐ Laboratory Report(s) ☐ Pathology Report(s) ☐ Office Visit Summaries

☐ Other (please specify) _____

*Initial _____ ** I understand that I am requesting my medical records be sent through unencrypted email. I understand there are risks involved in this transmission and it is possible for my Protected Health Information to be read or accessed by a third party. I accept these risks and do not hold Associates in Dermatology, Inc. responsible.*

I understand that I have a right to refuse to sign this RELEASE. I understand that this RELEASE is valid for 12 months from the date of signature below, unless otherwise noted. EXPIRES _____. I understand that there will be a fee for copying medical records. I understand that I may revoke this RELEASE at any time by notifying ASSOCIATES IN DERMATOLOGY in writing. The revocation will only be effective from the date it is received by ASSOCIATES IN DERMATOLOGY and will not apply retroactively.

_____ Date _____
Signature of patient or parent/guardian (if minor)

_____ Date _____
Printed name patient or parent/guardian (if minor)

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