# Shady Grove Dermatology, LLC

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## Authorization for Release of Medical Information

**Patient's Full Name** ____________________

**Patient's Date of Birth** ____________________

**Street Address** ____________________

**Patient's Telephone Number** ____________________

**City, State, and Zip Code** ____________________

At the request of the individual, I ____________________ (Patient's Name), do hereby authorize ____________________ (Name of Facility) to release:

The specific information that should be disclosed (including dates of service)

____________________

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____________________

**INFORMATION RELEASE TO:**

Name of Facility ____________________

Address (including City, State and Zip Code) ____________________

Phone Number ____________________ Fax Number ____________________

I hereby authorize disclosure of the health information for the above mentioned patient. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING**

| **Patient's Signature**<br>(The person about whom the information relates) | **Date** | **Date of Birth** |
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**FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies.**

**FAX: 240-477-4364**