ANNAPOLIS DERMATOLOGY ASSOCIATES

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients name: _____ Date of Birth: _____

Previous name: _____ Social Security# _____

I request and authorize _____ to release the healthcare information of the patient named above to:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

___ Operative Notes _____Dermatology office Notes _____ Pathology/Lab Reports

- Date(s) of Service _____Other: _____
-

Purpose of Need for Disclosure:

If being sent to a provider, please provide direct messaging address: _____

___Continued Patient Care ___Primary Care Provider ___Specialty Provider)

___Personal Use ___Insurance Claim ___Other (_____)

I understand that the cost for processing my request will be as followed:

$.76 per page of medical record

The actual postage cost

Preparation fee of $22.88 when applicable

Patient/Guardian Signature: _____ Date: _____

Witnessed By/Date: _____ Date mailed or given to patient: _____

This authorization expires ninety days after it is signed.

NO MEDICAL RECORDS WILL BE FAXED

2002 Medical Parkway, Suite 630
Annapolis, MD 21401
T 410.224.2260
F 410.224.3090

1630 Main Street, Suite 109
Chester, MD 21619
T 410.604.2424
F 410.604.1994