PHOENIXVILLE/VALLEY FORGE DERMATOLOGY ASSOCIATES
RECORD RELEASE
Authorization for Use and Disclosure

Patient Name: _____ D.O.B: _____

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

Phone: _____ Date of Service: _____

☐ I authorize _____ to disclose the following records related to the date above.

Records:
- ☐ Entire Medical Record
- ☐ Biopsy Reports
- ☐ Diagnostic Records (lab, x-ray, etc.)
- ☐ Office Notes from _____ to _____ (date / date)

To include:
- ☐ HIV/STD
- ☐ Drug and alcohol related

Please release these records to:

Name: _____

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

Phone: _____ Fax: _____

This information is being disclosed for the following purpose:

☐ Continuity of care ☐ Other: _____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request, and no longer protected by these regulations.

You may revoke this authorization in writing at any time by sending or faxing written notification to:

Phoenixville/Valley Forge Dermatology Associates
1260 Valley Forge Road, Suite 101
Phoenixville, PA 19460
Fax: 610-983-3406

Please note: Revocations do not apply to information that has already been disclosed or used before revocation has been received.

You have the right to receive a copy of this authorization. This authorization expires one year from date of signing or on _____.

Signature: _____ **Date:** _____

Parent/Legal Guardian/Authorized Person: _____ Date: _____

Relationship to Patient: _____