General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____ Date of Birth:_____/_____/_____

Address: _____

Phone: _____ SSN: _____

I authorize _____ to disclose/release the following information*
(check all applicable):

- ▫ All records
- ▫ Laboratory/pathology records
- ▫ X-ray/radiology records
- ▫ Office / Progress Notes
- ▫ Pharmacy/prescription records
- ▫ Other _____

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to (use this authorization as a cover sheet):

River Ridge Dermatology
Chad J. Johnston D.O.; F.A.A.D
3706 South Main St; Suite B
Blacksburg VA, 24060
(540) 951-DERM (3376)
FAX – (540) 951-1276

The information may be used/disclosed for each of the following purposes:

- ▫ At my request (only the patient can check this box)
- ▫ Treatment or Consultation
- ▫ Other: _____

This authorization shall expire 6 months from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) Date

_____ _____

Printed name Relationship of patient representative

(i.e parent, guardian, power of attorney for healthcare, executor)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to River Ridge Dermatology 3708 South Main St. Suite G Blacksburg VA, 24060.