Records Release Form

Date: ____/____/____

Patient Name: ______________________________________ DOB: ____/____/____ Phone #: ______-______-________

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION: PLEASE CHOOSE AN OPTION BELOW

☐ I authorize the release of my health information FROM the following to RidgeView Dermatology: ☐ Lynchburg Office ☐ Westlake Office

____
____
____
______-______-_________ Phone
______-______-_________ Fax

___ Entire Record ___ Lab Reports ___ Billing Statements
___ Surgery Reports ___ Office Notes ___ Hospital Reports
___ Pathology Reports ___ Diagnostic Imaging ___ Most Recent History
___ Medical Records needed for Continuity of Care

☐ I authorize the release of my health information from RidgeView Dermatology TO the following:

____
____
____
______-______-_________ Phone
______-______-_________ Fax

___ Entire Record ___ Lab Reports ___ Billing Statements
___ Surgery Reports ___ Office Notes ___ Hospital Reports
___ Pathology Reports ___ Diagnostic Imaging ___ Most Recent History
___ Medical Records needed for Continuity of Care

☐ I request a copy of my health information from RidgeView Dermatology at the cost of $5.00 for the first 10 pages and 0.25 cents per page thereafter.

** The following MUST be initialed to be included in the use or disclosure of other health information**

____ HIV/AIDS related health information and/or records
____ Mental health information and/or records
____ Genetic testing information and/or records
____ Drug/alcohol diagnosis, treatment and/or referral information

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This authorization shall be in effect until the information has been forwarded as requested.

I understand that my treatment will not be conditional upon signing this authorization and that I have the right to refuse to sign this authorization. I understand the information disclosed as a result of this authorization may be subjected to re-disclosure by the recipient and may no longer be protected by Federal or State Law. Any information received by this office for our own use will continue to be protected by Federal Privacy Rule. I understand that I have the right to revoke this authorization by sending a written notification to the address below and that revocation is not effective if the information has already been disclosed, but will be effective going forward. I understand that I have the right to inspect a copy of the protected health information as described in this document. I can do this by written notification to RidgeView Dermatology, 101 Candlewood Ct., Lynchburg, VA 24502.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient of Legal Representative

____
Description of Legal Representative's Authority

____
Parent Signature if Patient is under 18

____
Printed Name of Parent

JASON GIVAN, MD ♦ SAMANTHA HILL, MD ♦ CARRIE COBB, MD ♦ KRISTEN KUK, MD
ALEXIS CHANTAL, PA-C ♦ MEGAN ALLISON, PA-C ♦ JAMIE MARTIN, PA-C ♦ KAMAL CHANTAL, PA-C
MANDY WILKES-HOFFMEISTER, FNP-C
P - 434.363.4190 | F - 434.363.4191 | 101 CANDLEWOOD CT. LYNCHBURG, VA 24502
P - 540.759.7500 | F - 540.759.7501 | 278 WESTLAKE RD. HARDY, VA 24101
P - 434.333.7370 | F - 434.333.7371 | 300 ENTERPRISE DR. SUITE E. FOREST, VA 24551