Affiliated Dermatologists of Virginia
7813 Shrader Road
Henrico, VA 23294
(804) 264-4545 FAX: (804/264/4260

RELEASE OF RECORDS

I, _____ give permission for medical records to be released

_____ without limitation
_____ the following dates only _____
_____ other:_____

FROM: _____
_____
_____
_____

And sent **TO**:

_____
_____
_____
Phone_____
Fax_____

This authorization to release confidential information may be revoked at any time in writing, except to the extent that action already been taken in reliance upon it. It shall remain in effect long enough to fulfill its intended purpose or 60 days, whichever is sooner. No further confidential information shall be released without additional consent. I understand that I am not required to sign this consent and that I may refuse without any prejudice as to my future treatment. **A fee of .50/per page plus postage applies to records sent directly to a patient. There is no fee to fax records to another doctor's office.**

Patient Name_____ **DOB**_____

Address_____ Phone:_____
_____

_____ (__) self (__) parent/guardian
Signature

_____
Date

**ADOV maintains patient records for a minimum of six years from the last visit except in cases where by law, we are required to keep them longer.*