THE CLINICAL SKIN CENTER OF NORTHERN VIRGINIA, PLLC

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Today's Date: _______________

Patients Name:___________________________ Date of Birth:______________

Best number to reach you: (_____)_____-_________

I Authorize the Release of my Medical Records to:

Name of Recipient: ____

Address: ____

Phone: ________________ Fax:___________________

Please circle how you would like us to send your records: Mail or fax or Pick Up

I request a copy of the following medical records:

- Complete Medical Records
- Biopsy Report(s)
- Lab Report(s)
- Consultation Report(s)
- Other ____

For Dates of services from __________ to ___________

___________________________________ ________________

Patient Signature Date

___________________________________ ________________

Witness/Staff Signature Date

- **Signature confirmed with copy of photo ID**

Office Use Only			
Date:	Time:	• Picked Up • Faxed • Mailed	Initials:

3700 Joseph Siewick Drive, Suite 404, 402
Fairfax, Virginia 22033
www.ClinicalSkinCenter.com
(703) 620-8900 Fax : (703) 620-2288