mid-atlantic
skin surgery institute
SOUTHERN MARYLAND DERMATOLOGY

Verghese & Ling, MD PA

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

Patient Name: _____ DOB: _____ Phone: _____

Address of patient: _____

I, _____, hereby authorize Mid-Atlantic Skin Surgery Institute to release information from my medical record to:

OR:

I, _____, hereby authorize Mid-Atlantic Skin Surgery Institute to request information from my medical record from:

Please include name/address/fax below:

_____

_____

Are you releasing the records to yourself? YES/NO

Reason we are releasing the medical information:

_____ At my request (patient)

_____ Health Care purposes

_____ Changing physicians

_____ Employment

_____ For payment/insurance purposes

_____ Other: _____

I authorize the release of the following information:

_____ Visit Notes: ALL or DOS _____

_____ Pathology Results

_____ Consultation

_____ Financial ledger

_____ Lab Report

_____ Other: _____

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 the authority to sign this document and authorize its 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 guarantor) Date

_____ _____

Printed Name of patient guarantor Relationship to patient

173 St Patrick's Drive Suite 201 Waldorf, Md 20603
26840 Point Lookout Rd. Leonardtown, Md 20650
23415 Three Notch Road Suite 2052 California, Md 20619