INTEGRATED DERMATOLOGY GROUP

Dedicated to the Health and Well-Being of Our Patients

Rebecca T. Satoskar, MD
Integrated Dermatology of Fairfax

Authorization to Release Medical Records from Integrated Dermatology of Fairfax

Name of Patient _____
Date of Birth _____

I, the undersigned, authorize the release of all the information in the medical records of the above named patient, as further provided below.

The above information is to be released to:

Company/office/individual: _____

Address: _____

Facsimile: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and /or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV AND AIDS.

To cover the cost of copying and mailing. Preparation fee is $25, and .55 cents per page. Please allow 15 business days to release medical records.

The authorization will expire six (6) months from the date of my signature. However, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon the authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies. I hereby release Integrated Dermatology of Fairfax, LLC and its practitioners from any and all liability which may arise as a result of my authorized released of records.

Signature: _____ Date:_____

Printed name of Patient or Legally Authorized Representative

Relationship to Patient (if applicable)