Western Maryland Dermatology

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Name: _____ Account Number: _____

Date of Birth: _____/_____/_____ Phone Number: (_____) _____-_____

SSN: _____-_____-_____ Date: _____/_____/_____

I hereby authorize Drs. Mike McCagh, Ken Roberts, Sean McCagh and Dan Herring to release my medical records to the following:

Name: _____ Phone Number: (_____) _____-_____

Address: _____

Fax Number: (_____) _____-_____

The purpose or need for such disclosure is:

_____ Physician Use _____ Disability _____ Insurance

_____ Personal Use _____ Legal Reasons _____Other _____

I would like to have the following information released:

_____ Clinical Notes _____ Pathology Reports _____ All

_____ Lab Reports _____ Other

Date(s) Requesting: _____

I understand the following:

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about history, diagnosis and or treatment of drug or alcohol abuse, mental illness or communicable disease. I authorize the disclosure of this specific information. This authorization expires one year from the date of signature unless I specify otherwise or revoke it in writing. Federal and state laws indicate that a reasonable, cost-based fee may be charged for copies of healthcare records. I understand authorizing the use or disclosure of the health information identified above as voluntary.

_____ _____

Patient Signature or Authorized Person **Date**

_____ _____

Witness **Date**

Please allow a minimum of 72 hours for processing!

Please return completed releases to: (301)777-5381