VALLEY DERMATOLOGY, LLC

Keith A. Knoell, M.D.
Yara White, PA-C
Eli Crisler, FNP, DCNP
Emily Schweickert, PA-C

AUTHORIZATION FOR MEDICAL RELEASE

To/From Please transfer records

_____

_____

_____

To/From Valley Dermatology, LLC

2611 W Main St. Suite 1

Waynesboro, VA 22980

F: 540-221-6704 P: 540-221-6702

_____ All records
_____ Path Report (date/test/site requested) _____
_____ Blood Work Results (date/test requested) _____
_____ Billing/Insurance Needs (date requested)_____
_____ Specific Records (date/test requested) _____

_____ Other (describe) _____

Patient Rights and Signature

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any release of information that happened before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after being sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative/guardian.

Patient Name: _____ **DOB:**_____

Address: _____ **Phone:**_____

Patient or Personal Representative Signature:_____ **Date:**_____

_____

Printed name and description of Personal Representative's authority