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**DERMATOLOGY AND DERMATOLOGIC SURGERY**

**202-822-9591**

**FAX 202-775-1857**

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Authorization for Use or Disclosure of

Medical Record Information

**Patient Information:**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip:\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release information to (check one):**

I hereby authorize Drs. Isaacson & Berzin LLC to release my medical record information to the physician or facility listed below.

I hereby authorize the physician or facility listed below to release my medical information to Drs. Isaacson & Berzin LLC

Name/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip code\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Delivery Preference (check one):**

Mail/fax copies to address listed above Hold for patient pick up

Discuss medical information with (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be released (check one):**

Progressive notes only Laboratory notes only

Pathology reports only All records

Other (specify records needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose for Need or Disclosure (check one):**

Continued patient care Insurance claim/application

Attorney/legal Change of physician/relocation

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information released is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold any employee of Drs. Isaacson & Berzin LLC liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of Patient Relationship to Patient Date

(Self, parent, spouse)

Please fax completed form to (202) 775-1857 or mail to address above, attention Medical Records.