



**Authorization for the
Release of Protected Health Information**

Pantea Tamjidi, M.D., F.A.A.D.
Emily Porter Gerson, M.D., F.A.A.D.
M. Carol McNeely, M.D., Ph.D, F.A.A.D.
Soonyou Kwon, M.D., F.A.A.D.
Patricia Lucey, M.D., F.A.A.D.
Rachel White, PA-C
Natalie Lukaszewski, PA-C
Rachel Kokal, PA-C

As allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations, the purpose of this letter is to ask for copies of my medical records.

Patient name: _____ Date of birth: _____ Telephone #: _____

(Check **ONE** option) Tamjidi Skin Institute to send my records to:
 Tamjidi Skin Institute to obtain my records from:

Name of the medical office or authorized party: _____

Complete Street Address: _____

Telephone number: _____ Fax number: _____

I look forward to the requested party receiving the above records within 30 days as specified under the HIPAA. Please inform me if my request cannot be honored within the 30 days with the expected arrival date of my records.

I understand there may or may not be a cost associated with the request of my records. If any, I ask that you please bill me with the cost of providing copies of my medical records.

Patient Printed Name

Patient Signature

Date

Tamjidi Skin Institute
5454 Wisconsin Ave #1045
Chevy Chase MD 20185
T (301) 652-4828
F (301) 652-2070

8100 Boone Blvd #300
Vienna VA 22182
T (703) 345-6677
F (703) 506-0794