Dwana R. Shabazz, MD, MPH
Board Certified Dermatologist

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_ ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ______________________ To release healthcare information of the above named patient to

Street Address: ______________________

Renascance Dermatology
3620 Joseph Siewick Drive, Suite 303
Fairfax, VA 22033

City, State, Zip: ______________________

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

○ All healthcare information

I understand that it is my responsibility to confirm that Renascance Dermatology receives the above requested records.

Patient Signature: ______________________ Date signed: __________

THIS AUTHORIZATION EXPIRES ONE HUNDRED TWENTY DAYS AFTER IT IS SIGNED.