Authorization for Release of Medical Records

I authorize the following protected health information to be released from the medical record of:

Patient Name: _____ DOB: _____

Address: _____

_____

Phone: _____

Please Release my medical records to:

Dallas Center for Dermatology and Aesthetics
8201 Preston Rd., Suite 350
Dallas, TX 75225
Office (214) 631-7546
Fax (214) 631-8546

Release Records From:

_____

_____

_____

_____

Reason for the release of information:

□ At the request of the individual
□ Release to another physician or health professional

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests and x-rays.

_____ _____
PATIENT SIGNATURE DATE