DALLAS ASSOCIATED DERMATOLOGISTS

Authorization to Request Information

I hereby authorize Dallas Associated Dermatologists to request my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (“HIV’) and Acquired Immune Deficiency Syndrome (“AIDS’), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization.

I understand that my records may be subject to disclosure by the recipient, and may no longer be protected by federal privacy regulations.

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Print Patient Name Date of Birth

I authorize you to release the following specified protected health information to:

Dallas Associated Dermatologists, P.A. Phone: 214-987-3376
12700 Park Central Drive, Suite1210
Fax: 214-692-6567 Dallas, TX 75251

From the health records of:
Name of physician/facility/entity:____

____

Street Address

____

City, State, Zip Phone Number Fax Number

Check all protected health information that may be released:

- ❑ All Medical Records
- ❑ Patient Notes
- ❑ Visit Notes
- ❑ Path Reports
- ❑ Lab Reports
- ❑ Procedure Reports
- ❑ Medical History
- ❑ Other____________________

Dates may range:

From: ____________

To: ______________

Purpose of disclosure:

- ❑ Medical Care
- ❑ Insurance
- ❑ Attorney
- ❑ Other____
- ❑ At the request of the patient

I understand that this authorization will expire by law 180 days from the date of this authorization.

____ ______________________________

Signature of Patient or Patient’s Representative Date

____ or ______________________________

Printed Name of Patient’s Representative Legal Authority (attach supporting documents)

____ ______________________________

Relationship to Patient Dallas Associated Dermatologists Representative