DALLAS ASSOCIATED DERMATOLOGISTS

Authorization for RELEASE of Information

I hereby allow Dallas Associated Dermatologists to disclose my protected 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.

_____ _____
Print Patient Name Date of Birth

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

Name of physician/facility/entity _____

_____
Street Address

_____ _____
City, State, Zip Phone Number Fax Number

From the health records of: Dallas Associated Dermatologists, P.A.

Check all protected health information that may be released:

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

Dates may range:

From: _____

To: _____

Purpose of disclosure:

❑ Medical Care ❑ Attorney ❑ At the request of the patient
❑ Insurance ❑ Other_____

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