WHITE ROCK DERMATOLOGY
10611 Garland Rd., #210
Dallas, TX 75218
Tele: 214-324-2881 Fax: 214-328-4084

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I hereby authorize the release of information from the medical record of:

Patient_____ Date of Birth: _____

Social Security #_____ Daytime Phone: _____

INFORMATION RELEASED TO: **FROM:**

_____ _____

_____ _____

_____ _____

For Healthcare covering the period(s) from _____ to _____

PLEASE RELASE THE FOLLOWING:
_____Chart Notes _____Pathology Report(s) _____ Other (Specify)_____
including information (if applicable) pertaining to _____HIV/AIDS

PURPOSE OR NEED FOR DISCLOSURE:

____Continued Patient Care
____Attorney/Legal
____Disability Determination
____Personal Use
____Insurance Claim/Application
____Other (Specify)_____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness