WHITE ROCK DERMATOLOGY

Elizabeth Dolan, M.D.
10611 Garland Road, Suite 210
Dallas, TX 75218

Telephone: 214-324-2881 Fax: 214-324-4084

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Not infrequently we are asked to provide medical information related to your care to your primary care physician and/or to your insurance carrier to resolve issues related to charges. Spouses and/or children frequently request the results of laboratory studies and biopsy reports. Without your authorization, we cannot provide such basic information to anyone except you, the patient. This simple form is to allow you to provide that authorization, or to specifically deny such authorization when appropriate

I hereby authorize the release of information from my medical record to the following:

______ Primary Care Physician
______ Other Specialty Care Physician from whom I receive care
______ Spouse
______ Parents
______ Children and their spouses
______ Other (specify) ______________________________

(Please check any of the above that you specifically wish to include)

I understand that information released is for the purpose of providing quality continued patient care. 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.

May we leave medical information on your home answering machine if we are unable to reach you: **YES NO** (Please circle appropriate response)

Patient Name ______________________________ Date of Birth ____________________

______________________________ ____________________
Signature of Parent or Legal Representative Date
Parent or Legal Guardian must sign for patient
under 18 years of age

______________________________ ____________________
Relationship to Patient if other than self Witness

PLEASE SIGN

SO WE HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes, that I am responsible for all charges. I authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical benefits to which I am entitled to White Rock Dermatology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient Signature: ______________________________ Date: ____________________