High Plains Dermatology Center, P.A.

MEDICAL RECORDS RELEASE

DATE: _____

PATIENT NAME: _____ DOB: ____/_____/_____

ADDRESS: _____

_____

CITY STATE ZIP

RECORDS RELEASE TO:

Patient / Physician

Name:_____

Address:_____

City/State/Zip_____

Phone #:_____

Fax#:_____

Appointment Date: _____

RECORDS RELEASED BY:

High Plains Dermatology Center, PA
4302 Wolflin Ave.
Amarillo, TX 79106
Phone: (806)355-9866
Fax: (806)355-4004

By Signing below, I authorize High Plains Dermatology Center, PA to disclose and/or release certain protected health information (PHI) about me to the above named recipient.

____ Complete medical records ____Lab Reports Other_____

This authorization covers care provided from _____to_____.

Purpose of disclosure_____.

I understand that the following information released is for the specific purpose stated above and that there is a **$25 processing fee** for this service. Any other use of this information without 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 in 90 days after the date of my signature unless otherwise specified.

_____ _____

Signature of Patient or Patient's Legal Representative Date
(Please attach supporting documentation for legal representative)