SOUTHLAKE DERMATOLOGY
1170 N. Carroll Ave. Southlake, TX 76092
www.southlakedermatology.com
Main 817-251-6500 Fax 817-442-0550

Medical Records Release

This authorizes Southlake Dermatology to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information.

_____Complete record
_____Records of care from the following dates: _____to_____
_____Records concerning the following conditions:_____
_____Other, please specify: _____
_____Confer with person(s) listed below orally about my medical information.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Initials:_____ **Date:** _____

Release to the following person(s):

Name: _____

Street: _____

City: _____State: _____ Zip:_____

The reasons or purposes for this release of information are as follows:

_____

_____ _____
Patient Name (Printed) Date of Birth

_____ _____
Patient Signature or Parent/Legal Guardian Date:

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.