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

Medical Records Request

I hereby authorize
_____ to
release the following information from the health records of:

Patient Name: _____ DOB: _____

Address: _____

Covering the period(s) from _____ to _____

INFORMATION TO BE RELEASED:

_____ Copy of complete medical records _____ Lab Reports

_____ Biopsy reports only _____Other

INFORMATION TO BE RELEASED TO:

Southlake Dermatology
1170 N. Carroll Ave.
Southlake, TX 76092

Purpose of disclosure: _____
_____
_____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred. If revocation is not received, authorization will be considered valid for a period of time not to exceed 90 days.

Specification of the date, event, or condition upon which this consent expires: _____.

_____ _____
Patient Name (Printed) Date of Birth

_____ _____
Patient or Legal Guardian Signature Date