



431 E. State Hwy 114, Suite 300
Southlake, TX 76092
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
431 E. State Hwy 114, Suite 300
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