High Plains Dermatology Center, P.A.

MEDICAL RECORDS RELEASE

DATE: _____

PATIENT NAME: _____ DOB: ____/_____/_____

ADDRESS: _____

_____

CITY STATE ZIP

RECORDS RELEASE FROM:

_____

_____

_____

_____

Phone# _____Fax#:_____

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

By Signing below, I authorize the above institution to disclose and/or release certain protected health information (PHI) about me. My signature also permits a release of the following identifiable health information about me to **High Plains Dermatology Center, PA.**

____ Histopathology Report (Skin Cancers) ____Lab Reports(Last 2) ____Last 2 Office Visits

Purpose of disclosure: Continuation of Care_____.

I understand that the following information released is for the specific purpose stated above. 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 180 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)