

## 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  
(Please attach supporting documentation for legal representative)

\_\_\_\_\_  
Date