High Plains Dermatology Center, P.A.

**MEDICAL RECORDS RELEASE**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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CITY STATE ZIP

**RECORDS RELEASE FROM:**

**TO: High Plains Dermatology Center, PA**

**4302 Wolflin Ave.**

**Amarillo, TX 79106**

**Fax: (806)355-4004**

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Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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)