Mary E. Hurley, MD
Melissa I. Costner, MD
Erica L. Muller, MD
Melissa A. Rubenstein, MD
Sonya S. Jagwani, MD
Rachel A. Gordon, MD
Corinne L. Erickson, MD
Lauren B. Dickson, MD

8144 Walnut Hill Ln., Suite 1300, Dallas Texas 75231
Phone: 214-420-7070 Fax: 214-420-7380

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

to release healthcare information of the patient named above to:

Name: North Dallas Dermatology Associates -

Address: 8144 Walnut Hill Ln., Suite 1300

City: Dallas State: TX Zip Code: 75231

Phone: 214-420-7070 Fax: 214-420-7380

Disclose the following specific medical information by: Mail _____ Fax _____ Pick-up in person _____

My authorization extends only to those data elements/documents initialed below:

____Records of all visits
____Records of visits for a specific date or dates. Specific dates include or are limited to:_____
____Lab or Pathology reports
____Consultation Reports
____All of the above
____Financial Records
____Infectious disease Records

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a ninety (90) day period from the date it is signed.
4. North Dallas Dermatology Associates, PA., its employees, officers, and physicians are hereby released from any legal responsibility or liability or disclosure of the above information to the extent indicated and authorized herein.

Patient Signature (or Guardian if a minor): _____ Date signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.