AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, the undersigned, hereby authorize **Northstar Dermatology** to release the information specified below:

[ ] Office Visit Notes

[ ] Billing Records

[ ] Pathology Reports

[ ] Laboratory Reports

To:

Doctor/Office Name:	
Address:	
Fax Number:	Phone Number:

I understand that this authorization will expire in 90 days from the date of signature. I also understand this information may contain sensitive information about my health (STDs, HIV/AIDS, etc). This authorization may be cancelled at any time when the provider receives my notice in writing.

PATIENT SIGNATURE:	DATE:
PRINT NAME:	DOB:

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I, the undersigned, hereby authorize:

Doctor/Office Name:	
Address:	
Fax Number:	Phone Number:

To release the information specified below:

[ ] Office Visit Notes

[ ] Billing Records

[ ] Pathology Reports

[ ] Laboratory Report

To:

Northstar Dermatology
8169 Precinct Line Road, Building 2
North Richland Hills, TX 76182
Fax: 817.427.3379

I understand that this authorization will expire in 90 days from the date of signature. I also understand this information may contain sensitive information about my health (STDs, HIV/AIDS, etc). This authorization may be cancelled at any time when the provider receives my notice in writing.

PATIENT SIGNATURE:	DATE:
PRINT NAME:	DOB: