DERMATOLOGY CONSULTANTS OF FRISCO
AND
PRECISION DERMATOLOGY
Three Convenient Locations, One Great Team

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
TO DCF/PRECISION DERMATOLOGY

PATIENT INFORMATION (Please print):

Name: _____ **Date of Birth:** _____

Social Security Number: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

NAME: _____

ADDRESS: _____

_____

PHONE: _____

FAX: _____

Please release the following records to DCF/Precision Dermatology (Fax #972-668-8444):

_____

_____

I am aware of HIPAA regulations.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ **Date:** _____