

**Mid-Cities Dermatology Clinic**  
John David Miller, M.D., P.A.  
George C. Baker, M.D., P.A.  
Christopher K. Fuller, M.D.

1615 Hospital Pkwy. #306  
Bedford, TX 76022  
(817) 684-5100  
Fax: (817) 684-5120

**REQUEST AND AUTHORIZATION TO RELEASE INFORMATION**

**TO:** MEDICAL RECORDS DEPARTMENT Pt. Acct. # \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize Mid-Cities Dermatology Clinic, Doctor \_\_\_\_\_, to disclose identifying and medical information and/or records obtained in the course of the diagnosis and treatment of:

Name of Patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Social Security number: \_\_\_\_\_  
Phone number: \_\_\_\_\_

The information and/or records may be released only to the following:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
Fax number: \_\_\_\_\_

This disclosure shall be limited to the following types of specific information (if this item is not completed, the disclosure will be unlimited as to types of information):

- Office Notes       Operative Record       Lab Results       Records from year \_\_\_\_\_ to year \_\_\_\_\_  
 Other (please list) \_\_\_\_\_

The information will be used or disclosed for the following purpose:

\_\_\_\_\_

Records requested by: Patient \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Attorney \_\_\_\_\_ Other \_\_\_\_\_

The Practice will \_\_\_\_\_ will not \_\_\_\_\_ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

By signing my name at the end of this sentence, I specifically authorize you to include information pertaining to HIV testing and the diagnosis and/or treatment of HIV and/or AIDS.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. I understand that records pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illness, and alcohol or chemical abuse and dependency will not be released unless I have given my specific consent to release this information as indicated above. I do not have to sign this authorization in order to receive treatment from Mid-Cities Dermatology Clinic. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address listed below.*

**Mid-Cities Dermatology Clinic  
Attn: Privacy Officer  
1615 Hospital Pkwy. Suite 306  
Bedford, TX 76022**

\_\_\_\_\_  
Signature of Patient (or Legal Representative or Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorization expires on

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Records released by (Name)