MID CITIES DERMATOLOGY CLINIC
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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:

_____

Pt. Acct. # _____

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)