Medical Records Release Form

To: _____ Date: ____/_____/_____

By signing this form, I authorize you (named above) to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patient Name: _____ DOB: _____/_____/____

Address: _____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

Limitations on the information you may release subject to this Release Form are as follows:

None

Release my protected health information to the following person(s)/entity:

Rodgers Dermatology
3880 Parkwood Blvd, Suite 102
Frisco, TX 75034
Phone: 972-704-2400 **Fax: 972-704-2255**

Records to be released:

The purpose for this release of information is: **Continuity of Care**

_____ _____
Signature of patient (or parent, guardian or legal representative): Date

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.