Dermatology Center of Dallas 8230 Walnut Hill Lane, Suite 500 Dallas, TX 75231

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Dermatology Center of Dallas, must have my consent, therefore, I authorize Dermatology Center of Dallas to disclose my PHI as described in the provided forms, to the recipients listed below:

Description of the information to be dis	sclosed (check all that apply)
\square All Procedures \square Test Results \square Appointments \square Other \square Surgeries \square Billing/Account information	
Name(s) of the person(s) authorized to your referring doctor, family members a	obtain the above mentioned information. (e.g. Physician other than and other specified person/persons)
Name:	Relationship:
Contact Information:	
I authorize Dermatology Center of Dalla	as, to contact me at the following number with results or questions:
HomeCell	Work
May we leave a detailed message on your answering machine or voicemail?	
Yes□No□ Failure to check one of these boxes may delay results	
By Patient: (Print and sign)	
Date:	
Or Patient's Representative (Print name	e, sign and describe authority)
	Data

A copy of our Notice of Privacy Practices will be provided at your request.