LAS COLINAS DERMATOLOGY, P.A.

Disclosure and Consent

PATIENT AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OVER THE TELEPHONE OR FACSIMILE

I authorize **Las Colinas Dermatology, P.A.** to disclose my medical information pertaining to my diagnosis and/or treatment, laboratory test results, medical history, treatment, immunization records, or any other such related information to those listed below.

(Example: Referring Physician, Family Physician, Mother, Father, Spouse, Children, etc.)

1._____/_____/_____
Name of Entity Telephone Number Relationship

2._____/_____/_____
Name of Entity Telephone Number Relationship

3._____/_____/_____
Name of Entity Telephone Number Relationship

4._____/_____/_____
Name of Entity Telephone Number Relationship

5._____/_____/_____
Name of Entity Telephone Number Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons' not listed above will require a specific authorization prior to the disclosure of any medical information.

_____/_____
Name of Patient Date of Birth

_____/_____/_____
Signature of Patient/Legally Authorized Representative Date Relationship

_____/_____
Witness Date