

DERMATOLOGY CONSULTANTS OF FRISCO

AND

PRECISION DERMATOLOGY

Three Convenient Locations, One Great Team

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO DCF/PRECISION DERMATOLOGY

PATIENT INFORMATION (Please print):

Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

NAME: _____

ADDRESS: _____

PHONE: _____

FAX: _____

Please release the following records to DCF/Precision Dermatology (Fax #972-668-8444):

I am aware of HIPAA regulations.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date: _____

4685 ELDORADO PKWY, STE 100
FRISCO, TEXAS 75033
P. 972.335.2727
F. 972.668.8444

1601 W. HEBRON PKWY, STE 220
CARROLLTON, TEXAS 75010
P. 469.208.7181
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DENTON, TEXAS 76201
P. 940.312.6767
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