SKIN SPECIALISTS
ALLEN | ADDISON

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Skin Specialists of Allen, PA to release the information requested:

Information requested:_____

_____

_____

Send to:

_____

Name Fax Number Phone Number

_____

Street Address City State Zip

Please be aware that there is a charge for this service. We are authorized to charge $25.00 for the first 20 pages and $0.50 for every page thereafter as determined by the State of Texas. In addition, there may be a charge for all applicable mailing/ shipping costs. Please be aware the there is a 7 to 10 business day turnaround time on all records requests.

Name of Patient (Please Print)_____

Date of Birth: _____/_____/_____ Social Security #:_____-____-_____

Patient Signature_____ Date: _____

Please fax this completed form to our medical records department at 469-854-6224