



**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**