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 disclosed (check all that apply)

☐All Procedures☐Test Results☐Appointments☐Other☐Surgeries☐Billing/Account information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. Physician other than your referring doctor, family members and other specified person/persons)

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Contact Information:

I authorize Dermatology Center of Dallas, to contact me at the following number with results or questions:

Home_____Cell_____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, sign and describe authority)

_____Date:_____

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