INNOVATIVE DERMATOLOGY

Authorization to Request Information

I hereby authorize Innovative Dermatology to request my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV') and Acquired Immune Deficiency Syndrome ("AIDS'), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization.

I understand that my records may be subject to disclosure by the recipient, and may no longer be protected by federal privacy regulations.

Print Patient Name _____ Date of Birth _____

I authorize you to release the following specified protected health information to:

Innovative Dermatology
5425 W Spring Creek Pkwy Suite 150
Plano TX, 75024
Phone: 214-919-3500
Fax: 214-919-3501

From the health records of:

_____
Name of physician/facility/entity

_____
Street Address

_____
City, State, Zip Phone Number Fax Number

Check all protected health information that may be released: **Dates may range:**

- All Medical Records
- Patient Notes
- Visit Notes
- Path Reports
- Lab Reports
- Procedure Reports
- Medical History
- Other

From: _____

To: _____

Purpose of disclosure:

- Medical Care ❑ Attorney ❑ At the request of the patient
- Insurance ❑ Other: _____

I understand that this authorization will expire by law 180 days from the date of this authorization.

_____ _____
Signature of Patient or Patient's Representative Date

_____ OR _____
Printed Name of Patient's Representative Legal Authority (attach supporting documents)

_____ _____
Relationship to Patient Representative