Arlington Dermatology Clinic

MARY ADAMS, M. D.

DISEASES, CANCER & SURGERY OF SKIN
801 ROAD TO SIX FLAGS WEST #139
ARLINGTON, TEXAS 76012

TELEPHONE (817) 265-1356
FAX (817) 261-4309

Date: _____

Patient's Name: _____ Chart #: _____

Social Security#: _____ Patient's D.O.B.: _____

I authorize:

ARLINGTON DERMATOLOGY CLINIC, P.A.
801 Road to Six Flags West, Ste. 139
Arlington, Texas 76012

To Release Medical Records to:

This authorization shall remain in effect from the date signed below until I provide a written request revoking it.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting the office at the address above, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA
- This information may include information in HIC, AODS, Alcohol use, Drug use and Mental Health
- I may refuse to sign this authorization and that you will not condition treatment of payment on me providing this authoriztion

( ) If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient/Guardian Signature: _____ Date: _____