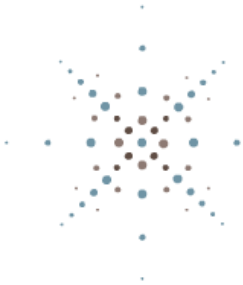

North STAR DERMATOLOGY

FAMILY SKIN CARE

5320 N. Tarrant Parkway, Suite 200
Fort Worth, TX 76244
Phone: 817-427-3376 Fax: 817-427-3379

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, the undersigned, hereby authorize:

Northstar Dermatology
5320 N. Tarrant Parkway, Ste. 200
Fort Worth, TX 76244
Fax (817) 427-3379

To release the information specified below:

Office Visits: _____

Pathology Reports: _____

Laboratory: _____

To:

_____

_____

_____

_____

I understand that this authorization will expire in 90 days from the date of signature. I also understand this information may contain sensitive information (STDs, HIV/AIDS, etc.). This authorization may be cancelled at any time when the provider receives my notice in writing.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____