NORTHSTAR
DERMATOLOGY

5320 North 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, Suite 200
Fort Worth, TX 76244
Fax (817) 427-3379

To release the information specified below:

Office Visit Notes: ☐

Pathology Reports: ☐

Laboratory Reports: ☐

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 about my health (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: _____

NORTHSTAR
DERMATOLOGY

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

AUTHORIZATION TO SEND MEDICAL RECORDS TO NORTHSTAR DERMATOLOGY

I, the undersigned, hereby authorize (Doctor/Office that will be sending medical records):

_____

_____

_____

_____

To release the information specified below:

Office Visit Notes: ☐

Pathology Reports: ☐

Laboratory Reports: ☐

To:

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

I understand that this authorization will expire in 90 days from the date of signature. I also understand this information may contain sensitive information about my health (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: _____