# 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) 427-3376

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: __________________

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DERMATOLOGY

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Fort Worth, TX 76244
Phone: 817-427-3376     Fax: 817-427-3379

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**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) 427-3376

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: __________________