NATALIE WRIGHT DERMATOLOGY
AUTHORIZATION TO RELEASE/ DISCLOSE MEDICAL RECORDS
Phone: 972.608.0330
Fax: 706.222.4019

PATIENT NAME: _____

DOB: _____

ADDRESS: _____

_____

PHONE: _____

TO RELEASE/ DISCLOSE THE FOLLOWING INFORMATION BY: MAIL ☐ **PATIENT PICK UP** ☐ **FAX** ☐

- **ALL RECORDS**
- **PROGRESS NOTES**
- **PATHOLOGY REPORT**
- **STATEMENT OF CHARGES/ PAYMENTS**
- **RECORDS FOR SPECIFIC DATE:** _____
- **OTHER:** _____

I AUTHORIZE FOR MY RECORDS TO BE RELEASED: TO ☐ **FROM** ☐

NATALIE WRIGHT DERMATOLOGY
6100 Windhaven Parkway
Plano, TX 75093
PHONE 972.608.0330
FAX 706.222.4019

RECORDS TO BE RELEASED: TO ☐ **FROM** ☐

PHYSICIAN'S NAME/ FACILITY/ HOSPITAL: _____

ADDRESS: _____

CITY, STATE, ZIPE CODE: _____

PHONE: _____ **FAX:** _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner, if noted below.
4. Natalie A. Wright, MD, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
(PATIENT'S SIGNATURE) **DATE**

_____ _____
(PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) **DATE**

_____ _____
(WITNESS SIGNATURE) **DATE**