MAGNOLIA
DERMATOLOGY

AUTHORIZATION TO REQUEST INFORMATION

I hereby authorize Magnolia Dermatology to request my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization.

I understand that my records may be subject to disclosure by the recipient, and may no longer be protected by federal privacy regulations.

Printed Patient Name:_____Date of Birth: _____

I authorized you to release the following specified protected health information to:

Magnolia Dermatology
13192 Dallas Parkway Ste 620
Frisco, Texas 75034
Fax: 972-668-7546 Phone: 972-668-3376

From the health records of :
Name of Physician/Facility/Entity_____
Street Address:_____
City, State, ZIP:_____Phone:_____FAX_____

Check all protected health information that may be released:

_____All Medical Records
_____Patient Notes
_____Visit Notes
_____Medical History
____Path Reports
____Lab Reports
____Procedure Reports
____Other_____

Dates may range:
From:_____
To:_____

Purpose of disclosure:

____Medical Care ____Attorney ____Insurance ___Other_____
____At the request of the patient

I understand that this authorization will expire by law 180 days from the date of this authorization.

_____ _____
Signature of the Patient or Patient's Representative **Date**

_____
Printed Name of Patient's Representative **(attach supporting documents)**

Relationship to Patient_____

Carla Gustovich, M.D., Rachel Quinby-Graves, M.D.
13192 Dallas Parkway Suite 620, Frisco, Texas 75034 972-668-3376 972-668-7546 fax