Allergy and Dermatology Specialists

LONGEVITY PHYSICIAN SPECIALISTS

Allergy Division

Eric Schmitt, MD ● Mike Calvin, PA-C

Dermatology Division

Lucy Li, MD ●Nancy Chung, MD

Bradley Armstrong, PA-C ● Katie Vo, PA-C ● Mary Gurney, PA-C

OUTBOUND MEDICAL RELEASE FORM

PATIENT NAME: _____PATIENT DOB: _____

I authorize Allergy and Dermatology Specialists to release the listed medical information to:

_____

NAME OF PHYSICIAN/COMPANY

_____

ADDRESS

_____ _____

PHONE NUMBER FAX NUMBER

Please circle the clinic from which records are needed: **ALLERGY** **DERMATOLOGY** **BOTH**

The information covered by this authorization includes:

- ○ COMPLETE MEDICAL RECORDS
- ○ MEDICAL SUMMARY (list the dates you would like disclosed) _____
- ○ OFFICE NOTES (specify the doctor's name and date service) _____
- ○ PATHOLOGY RESULTS (please list the dates or types of lab tests you would like disclosed) _____
- ○ LAB RESULTS (please list the dates or types of lab tests you would like disclosed) _____
- ○ OTHER _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that once the above information is disclosed, it may be disclosed again by the recipient and the information may not be protected by federal privacy laws or regulations

This authorization will expire on _____ unless revoked or terminated by the patient or patient's personal representative.

Failing to specify an expiration date, this authorization will in 12 months. You may revoke or terminate this authorization at any time by submitting a written revocation to this office and contact the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization.

The use or disclosure requested under this authorization can result in direct or indirect remuneration to this office.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

Print Name _____ Signature _____ Date _____

Patient Representative _____ Signature _____ Date _____

9191 Kyser Way Bldg.3, Ste.B
Frisco, TX 75033
T: 972-712-3131
F: 972-712-7171
www.dermfrisco.com

580 S. Denton Tap Rd. Ste.290
Coppell, TX 75019
T: 972-712-3131
F: 972-712-7171
www.dermcoppell.com

3317 Unicorn Lake Blvd, Bldg.4, Ste.142
Denton, TX 76210
T: 940-222-3724
F: 972-712-7171
www.dermdenton.com

817 Towne Court, Ste 200
Saginaw, TX 76179
T: 817-529-1400
F: 972-712-7171
www.dermsaginaw.com