MARK
RAY
MD
DERMATOLOGY

Authorization to Request Information

I hereby authorize MARK RAY MD DERMATOLOGY PLLC to request my individually identifiable health information as described below, which may include information concerning communicable diseases 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.

_____

Print Patient Name Date of Birth

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

MARK RAY MD DERMATOLOGY PLLC
2601 Little Elm Parkway, Suite 101
Little Elm, TX 75068

Phone: (972) 988-9945
Fax: (469) 393-7707

From the health records of:
Name of physician/facility/entity:_____

_____

Street Address

_____

City, State, Zip Phone Number Fax Number

These Records may be:

❑ Mailed to above address
❑ Faxed to above fax number
❑ Transferred Electronically (only available in patient portal)
❑ Handed Directly to Me In Person

Check all protected health information that may be released:

❑ All Medical Records ❑ Path Reports
❑ Patient Notes ❑ Lab Reports
❑ Visit Notes ❑ Procedure Reports
❑ Medical History
❑ Other_____

Dates may range:

From: _____

To: _____

Purpose of disclosure:

❑ Medical Care ❑ Attorney ❑ At the request of the patient
❑ Insurance ❑ Other_____

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

_____ _____

Signature of Patient or Patient's Representative Date

_____ or _____

Printed Name of Patient's Representative Legal Authority (attach supporting documents)

_____

Relationship to Patient