Allergy and Dermatology Specialists

LONGEVITY PHYSICIAN SPECIALISTS

Dermatology Division

Lucy Li, MD ●Nancy Chung, MD
Bradley Armstrong, PA-C ●Katie Vo, PA-C ● Mary Gurney, PA-C

MEDICAL RELEASE FORM

PATIENT NAME: _____ **PATIENT DOB: _____**

I authorize _____ to release the listed medical information to **Allergy & Dermatology Specialists** at 9191 Kyser Way, Bldg 3 Frisco TX 75033.

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.

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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_____