K. Robin Carder, MD

8315 Walnut Hill Lane, Suite #135, Dallas, TX 75231

Phone#: 214-580-1011 Fax#: 214-580-1012

Authorization for Release of Medical Records/Information

Date of Request: _____

Patient Name: _____

Date of Birth: _____

I, _____, authorize the release of _____
Parent/Guardian Name (print) Child's Name

medical information to/from Pediatric Dermatology of Dallas, PA. Please include all clinical notes, laboratory or pathology reports, and/or other clinical information. **Please fax records to (214) 580-1012 or mail them to 8315 Walnut Hill Lane, Suite #135, Dallas, TX 75231.**

Sincerely,

_____
Signature

Name of facility/office/physician requesting records to be sent to/from:

_____

Phone #: _____

Fax #: _____