



# Ivy Dermatology & Surgery Clinic

1209 Hall Johnson Rd

Colleyville, TX 76034

ClinicIvy.com

Phone/Fax: (817) 888 – 8524

<b>Patient Name</b>			
<b>Date of Birth</b>		<b>Phone</b>	

Authorization to release /disclose the following information by:

Mail  Fax  Patient pick-up

All records  Progress Notes  Pathology Report

Other:

I authorize for my records to be released: To \_\_\_\_\_ From \_\_\_\_\_

**Ivy Dermatology & Surgery Clinic | Phone/Fax: (817) 888 - 8524**  
1209 Hall Johnson Rd, Colleyville TX 76034

Records to be released: To \_\_\_\_\_ From \_\_\_\_\_

Physician's Name/Facility/Hospital:

Address:

Phone:

Fax:

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner, if noted below.
4. Pooyan Rohani, MD, Ivy Dermatology & Surgery Clinic and its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_