

HOWSDEN DERMATOLOGY

F. LESTER HOWSDEN, MD

AKASH A. PATEL, MD

1919 S. SHILOH ROAD

STE. 300, LB42

GARLAND, TEXAS 75042

TELE: 972-278-4992

FAX: 972-271-1597

**AUTHORIZATION TO RELEASE COPY OF
MEDICAL RECORD DIRECTLY TO PATIENT**

Patient: _____

DOB: _____

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold F. Lester Howsden, MD nor Akash A. Patel, MD liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness

Office Use Only

Chart Notes dated _____ Path Report dated _____ Other dated _____

Mail to patient address _____

Given to patient in office by _____

Fax to: _____

Fax number: _____

Sent by _____ (initials) on _____ (date)

Dr. _____