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711 E. Lamar Blvd. Suite 200 • Arlington, Texas 76011

Patient Name: _____

Date: _____

**ASSIGNMENT OF INSURANCE BENEFITS AND
MEDICAL INFORMATION RELEASE AUTHORIZATION**

Insurance Benefits: I authorize the release of information necessary to process any claim. I certify the information I supply is true and correct to the best of my knowledge

I authorize payment of medical benefits to be made on my behalf to Arlington Center for Dermatology. I authorize photocopies of this form to be valid as the original.

Consent to treat: I authorize medical procedures to be performed on the patient named below at the direction of the physician(s) of Arlington Center for Dermatology.

Release of Medical Information: I authorize Arlington Center for Dermatology to release medical information (including chart notes, lab results, pathology results) to my primary care physician and/or specific healthcare provider requesting such information in regards to my healthcare,

I authorize Arlington Center for Dermatology to release medical information over the telephone to the following:

_____ myself only

_____ listed persons in my household:

_____ results may be left on voice mail at this number

Signature on file: I acknowledge that I have read and agree to be bound by the terms stated above. The duration of this authorization is indefinite or until it is revoked in writing

Patient signature: _____