AUSTIN DERMCARE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, the undersigned, do hereby authorize Dr. _____
to release the information from the medical record of:

_____ _____ _____
PATIENT NAME (PLEASE PRINT) **D.O.B.** **SOCIAL SECURITY NUMBER**

Records Are To Be: [ ] Given To: [ ] Mailed To:

_____

_____

_____

Information To Be Released:
[ ] Dermatology Records [ ] Pathology Report(s) _____
[ ] Laboratory Report(s) _____ [ ] Consultation
[ ] History & Physical [ ] Progress Notes [ ] HIV/AIDS Information
[ ] All of the Above [ ] _____

Reason For Release of Information:
[ ] Application for Insurance Claim or Coverage [ ] Worker's Compensation
[ ] Release to Another Physician or Health Professional
[ ] Other: _____

(Article 4495b, Section 5.08 (j) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reasons or purposes for the release.")

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This authorization expires automatically ninety (90) days from the date of signature.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Relationship To Patient Witness

_____
Reason Patient is Unable To Sign

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