AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____
(First) (MI) (Last)

Date of Birth: _____ Social Security #: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Release Information (check one):

☐I hereby authorize Houston Institute of Dermatology to release my medical record information to the physician or facility listed below.

☐I hereby authorize the physician or facility listed below to release my medical information to Houston Institute of Dermatology.

Physician or Clinic Name: _____

Address: _____

City: _____ State _____ Zip_____

Fax: _____ Telephone: _____

Delivery Preference (check one):

☐Mail/fax copies to address listed above ☐Hold for patient pick-up

Information To Be Released (check one):

☐Progress notes only ☐Laboratory notes only ☐Pathology reports only ☐All records

☐Other (specify records needed): _____

Purpose for Need or Disclosure (check one):

Article 449b, Section 5.08 (j) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reason or purpose for the release".

☐Continued patient care ☐ Insurance claim/application ☐Attorney/legal

☐Change of physician/relocation ☐Other: _____

I understand that the information released is for the specific purpose stated above. 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 any employee of Houston Institute of Dermatology liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken.

Patient/Guardian Signature: _____

Printed Name_____ **Date:** _____