

**Authorization for Use or Disclosure of Protected Health Information to Austin Skin**

***I authorize the Medical Record Custodian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ to release information from the medical record of:***

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Dates of Service: \_\_\_**\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFORMATION MAY BE RELEASED TO: **AUSTIN SKIN** INFORMATION WILL BE RELEASED FROM:

Kristina Collins MD or Sarah Gee MD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dermatologist Practice Name / **Doctor Name**

1501 B Dorothy Nichols Road\_\_Smithville TX\_78957\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address, City, State, Zip Address, City, State, Zip

737-727-7546\_\_\_\_\_\_\_\_\_\_\_\_ 737-843-1085\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Fax Phone Fax

|  |
| --- |
| **Please release the following information:** |
| * Patient Progress Notes- Medical and Surgical
* Pathology Reports
* Laboratory Reports
 | * Patient Photos
* All Records
 |

|  |
| --- |
| **Purpose of Request 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.”* |
| * Continuing Patient Care
* Change of Physician
* Personal
 | * Insurance Purposes
* Relocation
* Other
 |

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient Relationship to Patient Date**

 (self/spouse/parent/power of attorney)