AUSTIN SKIN
medical + surgical + cosmetic dermatology

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:

Date of Birth: DD / MM / YYYY

Patient's Full Address:

I authorize Austin Skin, LLC to:

☐ **Send** copies of your medical record (or discuss information with) the provider/person/facility below.

☐ **Receive** copies of your medical record (or discuss information with) the provider/person/facility below.

Name of Provider/ Person/Facility:

Full Address:

Office Phone:

Office Fax:

Information to be disclosed:

☐ Patient Progress Notes - Medical and Surgical ☐ Pathology Reports ☐ Pathology Slides

☐ Laboratory Reports ☐ Patient Photos ☐ All Records

Purpose of Request or Disclosure: *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

Restrictions: *Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information including the date on this authorization unless other dates are specified. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request to Austin Skin LLC.*

I have read the above foregoing Authorization for Release of medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative Signature:

Date: DD / MM / YYYY

Printed Name of Authorized Representative:

Parent/ Guardian signature required for patients less than 18 years of age.

Signature of Parent/Guardian:

Relationship:

Printed Name of Parent/Guardian:

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