

Authorization for Use or Disclosure of Medical Record Information

Patient Information:

Patient Name: _____ DOB: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____

Release Information To (check one):

- I hereby authorize Westlake 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 Westlake Dermatology.

Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____

Delivery Preference (check one):

- Mail/fax copies to address listed above Hold for patient pick-up
 Discuss medical information with: (name) _____, (phone) _____

Information To Be Released (check one):

- Progress notes only Laboratory notes only
 Pathology reports only All records
 Other (specify records needed): _____

Note: Westlake Dermatology does not provide copies of records received from another facility/institution. Please request these records directly from the original healthcare provider.

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 Westlake 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. This consent will expire 90 days after the date of my signature.

Signature of Patient

Relationship to Patient (self, parent, spouse)

Date