WESTLAKE DERMATOLOGY & Cosmetic Surgery

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): _____

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

Please fax completed form to (512) 306.0222 or mail to address below, attention Medical Records.

Westlake Dermatology | 8825 Bee Caves Road | Austin, TX 78746 | Phone 512.328.3376 | Fax 512.306.0222

For office use only. Staff initials: _____ Date/time handled: _____ Means of transmittal: _____