WESTLAKE DERMATOLOGY & Cosmetic Surgery

PMS ID

Authorization for Use or Disclosure of Protected Health Information to Westlake Dermatology

I authorize the Medical Record Custodian of _____ to release information from the medical record of:

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Date(s) of Service: _____

Information May Be Released To: WESTLAKE DERMATOLOGY

Dr. Adam Mamelak
Westlake Dermatology Provider

_____
Westlake Dermatology Location

_____
Address, City, State, Zip

512-328-3376 x3184 **512-615-3184**
Phone Fax

Information Will Be Released From:

Sanova Dermatology
Practice/Doctor

12319 N. Mopac Expressway Ste 100
Address

Austin, TX 78758
City, State, Zip

512-837-3376 **512-837-3377**
Phone Fax

Please release the following information:

- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Other (specify records needed): _____
- ☐ Laboratory Reports
- ☐ 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."*

- ☐ Continued Patient Care
- ☐ Attorney/Legal
- ☐ Other: _____
- ☐ Insurance Claim/Application
- ☐ Change of Physician/Relocation
- ☐ Personal Use

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) 615-3184, attention: Medical Records.