

Authorization for Use or Disclosure of Medical Record Information

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Release Information To

I hereby authorize Bee Caves Dermatology to release my medical record information to

I hereby authorize the Physician or Facility listed below to release my medical information to Bee Caves Dermatology, the office of Mary Ann Martinez, M.D.

Mail/Fax Copies To: Hold for Patient Pick-up Discuss Medical Information With:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Information to be Released

Progress Notes Laboratory Reports Pathology Reports

Specific Records Needed: _____

Bee Caves Dermatology does not provide copies of records received for another physician or institution. Please request these records directly from the original healthcare provider.

Purpose for Need 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.")

Continued patient care Insurance Claim/Application Attorney/Legal

There is a charge of \$25.00 for the first 20 pages and 50 cents per page for every copy thereafter. In addition, you may be charged a reasonable administrative fee covering actual costs for mailing, shipping, or delivery. 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 Bee Caves 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 been taken in reliance on it. This consent will expire 90 days after the date of my signature unless other wise specified.

Signature of Patient or Legal Guardian

Date

Relationship to Patient (self, parent, spouse)

Witness Signature

*****please confirm you have completed ALL protected information categories above regardless if they are applicable or not. If form is incomplete we will be unable to fulfill your request*****