AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

All records need to be mailed or faxed to our Austin office.

3500 Jefferson St. Suite 200 Austin, TX 78731 Phone: 512-451-0139 Fax: 512-323-5880

Highlighted areas need to be filled out completely for request to be processed

I, _____, DOB: _____, hereby authorize the use and/or disclosure of my health information to be released from the following individual/organization:

_____ Fax Number: _____

And disclosed to the following individual/organization:

_____ Fax Number: _____

******* I understand that there is a fee for this service: Fees will be collected prior to records being sent *******

☐ Paper charts-$25 for the first 20 pages and 50 cents for each additional page plus shipping fees

☐ Charts sent electronically-$25 for up to 500 pages and $50 for more than 500 pages

☐ Fee is waived if sent directly to another provider.

Information to be released: ☐History & Physical ☐Progress Notes ☐Path or Labs ☐HIV/AIDS information

☐Entire medical record ☐Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐Yes, I consent to the release of this information ☐No, I do not consent to the release of this information

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request OR upon the following date: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office of TRU-SKIN DERMATOLOGY

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record contains 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 TRU-SKIN DERMATOLOGY liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Witness

Revised 8/2021