Central Texas Dermatology Clinic 102 Westlake Drive Austin, Texas 78746

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Date of Birth: _____
Social Security #: _____ Daytime Phone: _____

I authorize the following individual or organization to disclose the above named individual's health information:
_____ Address: _____
This information may be disclosed TO and used by the following individual or organization:
_____ Address: _____

Please release the following:
☐ Progress Notes ☐ Pathology Reports ☐ Lab Reports ☐ Any and all Records
☐ Other Diagnostic reports (Specify)_____
☐ Other (specify)_____
Including Information (if applicable) pertaining to:
☐ Mental Health ☐ Drug/Alcohol ☐ HIV/AIDS ☐ Communicable Treatment

Purpose or Need for Disclosure:
☐ Continued Patient Care ☐ Personal Use
☐ Attorney/Legal ☐ Insurance Claim/Application
☐ Disability Determination ☐ Other (specify)_____

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.

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 that 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 the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on following date, event or condition:_____
_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need to not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 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 Christie Black at 512-327-7779.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
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 Central Texas Dermatology liable for any misinterpretation of the information in my medical record as a result of not contacting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Dr. review/signature/date _____
Date request completed _____ # of pages copied _____
Staff Signature _____