DERMATOLOGY SAN ANTONIO

Diplomats of the American Board of Dermatology
General, Surgical and Cosmetic Dermatology

Shavano Commons Business Park **Helotes Country Village** **Westover Hills**

Authorization to Release Protected Healthcare Information to Designated Representative(s)

I, _____, _____ / _____ / _____, give my authorization
(*Patient*) (*DOB*)

release my Protected Health Information, including records and results of my laboratory test, x-ray, or biopsy results to the following designated representative(s):

_____ My spouse (*name*) _____

_____ My child (*name*) _____

_____ Other (*name*) _____

_____ Personal Representative _____

_____ May be left on home answering machine (*home number*) _____ - _____ - _____

_____ May be left at my work answering machine *(work number*) _____ - _____ - _____

_____ May be left on my cell phone (*cell number*) _____ - _____ - _____

_____ May send an encrypted email _____

_____ **MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF**

Signature: _____ _____ / _____ / _____
(*Patient/Legal Guardian*) (*Date*)

As a patient, you have the right to revoke this Authorization in writing at any time, except to the extent that action has been taken in reliance on this Authorization or, if applicable, during a contestability period. In order for the revocation of this Authorization to be effective, Dermatology San Antonio must receive the revocation ***in writing****.*