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 for Release of Healthcare Information To or from Medical Providers

Patient Name: _____ Date of Birth: _____ / _____ / _____

I hereby authorize the transfer of the following healthcare information:

☐ **To** ☐ **From** Dermatology San Antonio
16110 Via Shavano
San Antonio, TX 78249
Phone: 210.615.7171_
Fax: 210.615.6793

☐ **To** ☐ **From** _____
Fax: _____ - _____ - _____Phone: _____ - _____ - _____
Attention: _____

☐ Dr. Miller ☐ Dr. Tisdall ☐ Dr. Cragun ☐ Dr. McCarroll ☐ Dr. Brown ☐ Dr. Bowen

☐ Erin Lenza, PA-C ☐ Mui Lee, PA-C ☐ Felipe Galvan, PA-C

TO RELEASE:

☐ Entire contents of chart

OR (*specify particular portions of chart*)

☐ Progress Notes ☐ Pathology ☐ Lab Reports

☐ Correspondence ☐ Operative Reports

PURPOSE OF DISCLOSURE: ☐ Continuing Patient Care ☐ Other

I understand the specific information to be released may include, but not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illness or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I also understand this Authorization is subject to revocation/withdrawal by me at any time by writing to Dermatology San Antonio, except to the extent that action has already been taken to release the information. This Authorization shall remain valid unless revoked, but will expire one year after signing. I have the right to inspect a copy of the health information to be released, and if I do not sign the Authorization, Dermatology San Antonio will not release my health information. As a parent or legal representative signing this Authorization, I do understand that Dermatology San Antonio cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

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