DERMATOLOGY SAN ANTONIO

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

Shavano Commons Business Park **Helotes Country Village** **Westover Hills** **Bulverde/Spring Branch**

Authorization for Release of Healthcare Information

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

I hereby authorize the transfer of the following healthcare information:

Dermatology San Antonio ☐ **To** ☐ **From** _____
Phone: (210) 615-7171 Fax: _____ - _____ - _____ Phone: _____ - _____ - _____
Fax: (210) 615-6793 Attention: _____

☐ Dr. Miller ☐ Dr. Tisdall ☐ Dr. C. Cragun ☐ Dr. McCarroll ☐ Dr. T. Cragun ☐ Dr. Dalton

☐ Erin Lenza, PA-C ☐ Mui Lee, PA-C ☐ Natalie Marshall, PA-C

TO RELEASE:

☐ Entire contents of chart **OR** ☐ Progress Notes ☐ Pathology

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: _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian
☐ Other_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE: _____ _____
Signature of Minor Individual **Date**