**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| [ ] Dr. Miller [ ] Dr. Tisdall [ ] Dr. C. Cragun [ ] Dr. McCarroll [ ] Dr. T. Cragun [ ] Dr. Dalton [ ] Dr. Lenz [ ] Mui Lee, PA-C [ ] Natalie Marshall, PA-C [ ] Lavonne Stumbaugh FNP-C [ ] Cesar Veliz 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Individual or Individual’s or Individual’s Legally Authorized Representative (Date)

Print 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