AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Purpose for this request:

__ Further evaluation and treatment ____ Continuity of Care ____ Personal

__ Relocation __ Other_____

I authorize and request Friendswood Dermatology, to release the following:

____ Entire Records ____ Last Visit ____ Lab Results

____ Other _____

To:

Dr. / Facility Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

Signature of Patient or Representative: _____Date: _____

Relationship to Patient (if requester is not the patient) _____

Witness: _____ Date: _____

Name: _____

SS#: _____ DOB: _____

I understand that:

If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed. The physician and employees are release from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Pursuant to HIPAA Privacy Rule: *Your provider is allowed to charge you a fee for the requested records. Charges are for personal use $1.00 per page, up to 25 pages then $0.50 every page after that. There will be NO CHARGE to send your records to another Doctor.*

Friendswood Dermatology
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