LAKEWAY DERMATOLOGY
Skin Cancer, Cosmetic & Laser Center

Authorization for Release of Medical Records

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

Release records to:

Name: _____

Fax: _____

Lakeway Dermatology
Attention: Medical Records
3464 RR 620 South
Bee Cave, TX 78738

Phone: 512-263-0057
Fax: 512-263-0221

Release records from:

Name: _____

Fax: _____

I request a copy or summary of the following medical records:

____ Complete Medical Records
____ Pathology Report(s)
____ Lab Report(s)
____ Other _____
____ Consultation Report(s)
____ Allergy Test/Treatment
____ Surgical Procedure(s)

Please Check one:

____ For dates of service from _____/_____/_____ to ____/____/_____
____ For all dates of service

Purpose:

____ Continued Care ____ Insurance ____ Personal ____ Other

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____ Yes, I consent to the release of this information.
____ No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires within one year of completion of this request.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office of Lakeway Dermatology.

I understand that there may be a reasonable medical records copying fee as permissible by state law.

_____ _____
Patient Signature Date

FOR OFFICE USE ONLY:

Physician Approval and Date: _____ Means of Transmittal: _____

Staff Initials: _____ Date Handled: _____