HOUSTONskin

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

From Houston Skin (HSA) to another physician/facility

I hereby authorize:
Name/Facility: HOUSTON SKIN ASSOCIATES

Address: _____

Phone: _____ Fax: _____

To Release To:
Name/Facility: _____

Address: _____

Phone: _____ Fax: _____

The information from the hospital/clinic medical records on:

Patient Name: _____ DOB: _____

Patient Address: _____

SSN: _____ Guardian Name (if Applicable): _____

Admit/Treatment Date(s): _____

I hereby authorize the release of the following information, including if applicable, any treatment or test results for alcohol and/or drug abuse, or reportable communicable diseases, including acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus infection (HIV).

___ Inpatient Data ___ Outpatient Data ___ Emergency Report Other: _____

*The above information is requested for the following purpose and that purpose only: Patient is being treated at this clinic.

I understand that I may revoke, in writing, this authorization at any time, but not retroactive to the release of information made in good faith.

This authorization will expire one year from the date of my signature or as otherwise specified by date, event, or condition as follows: _____

Patient Signature _____ Date _____

I hereby consent on his/her behalf and in his/her stead.

_____ _____ _____
Signature of Legal Representative Print Name Date

CLEAR LAKE/ WEBSTER
451 N Texas Avenue
Webster, TX 77598
PH: 281-333-3376
Fax: 832-632-2103

HOUSTON
1401 Binz Street, Suite 200
Houston, TX 77004
PH: 281-333-3376
Fax: 281-888-8495

PEARLAND
10907 Memorial Hermann Dr., Suite 170
Houston, TX 77584
PH: 281-333-3376
Fax: 281-949-8608