DERMATOLOGY ASSOCIATES OF SAN ANTONIO

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AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

______________________________ ______________
Name of Patient (Please Print) Date of Birth

______________________________ ______________
Street Address City State Zip Phone Number

____
Maiden Name or Other Name Used for Records

I here by authorize (please print):
Name:______________________
Address:______________________
Phone #/Fax#______________________

To Release to (please print):
Name:______________________
Address:______________________
Phone #/Fax#______________________

The following information from my records:

- ☐ Complete health Record(s)
- ☐ Pathology reports
- ☐ Operative Report(s)
- ☐ Progress notes
- ☐ Laboratory Report(s)
- ☐ Other (please specify): ______________________.

I ☐ do ☐ do not (check applicable box) authorize this information to be faxed. If yes, fax number:______________________.

Covering the period from ______________ to ______________.

_____ (Initial) I understand that this authorization may include information relating to:

- ✓ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency syndrome (HIV) infection.
- ✓ Psychiatric care.
- ✓ Treatment for alcohol and/or drug abuse.
- ✓ Genetic testing.

If any, except as specifically stated here: ______________________.

This information is to be disclosed for the purpose of ______________________.

The date, extent or condition upon which this authorization expires is __________ (not to exceed 24 months except for reasonable purpose, state "NONE" for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability of obtain treatment or payment, or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other than Dermatology Associates of San Antonio and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of sun incorporated records). I expressly request release of all records maintained by Dermatology Associates of San Antonio concerning me, including incorporated records. I acknowledge that Dermatology Associates of San Antonio has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release to Dermatology Associates of San Antonio and it personnel from all legal responsibility that may arise from the act I have authorized above. Dermatology Associates of San Antonio is not responsible for completeness, legibility or omissions caused by the copying of any medical records from another institution.

______________________________ ______________
Signature of patient or patient's representative Date

Printed name of patient's representative______________________ Relationship to patient ______________.

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Prohibition on re-disclosure: This information which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined or imprisoned.