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 authorize Dermatology Associates of San Antonio ***to release information to:***	☐ I authorize Dermatology Associates of San Antonio ***to obtain information from:***
________________________________ Name of Provider or Facility	________________________________ Name of Provider or Facility
________________________________ Address	________________________________ Address
________________________________ City, State, Zip Code	________________________________ City, State, Zip Code
________________________________ Phone# / Fax# (include area code)	________________________________ Phone# / Fax# (include area code)

PURPOSE FOR THIS REQUEST: ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Transfer of Care ☐ Other

The following information from my records:

- ☐ Complete Health Record(s)
- ☐ Operative Report(s)
- ☐ Laboratory Report(s)
- ☐ Pathology Reports
- ☐ Progress Notes
- ☐ Other (please specify): ______________________________.

_____ (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: ______________________________________.

Covering the period from ____________________ to ______________________.

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 of 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 Dermatology Associates of San Antonio and its 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 ____________________

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.