THE WOODLANDS
DERMATOLOGY
ASSOCIATES

Authorization for Release of Healthcare Information

Patient Name: _____

Date of Birth: _____

I hereby authorize the transfer of the following healthcare information:

To: _____

_____

_____

_____

From: The Woodlands Dermatology Associates
9303 Pinecroft Dr, Suite 150
The Woodlands, TX 77380
Phone: (281) 363-5050 Fax (281) 363-5020

☐ Entire contents of chart

OR (specify particular portions of chart)

☐ Progress Notes ☐ Pathology ☐ Lab reports

☐ Correspondence ☐ Operative reports

Purpose of Disclosure: ☐ Continuing Patient Care ☐ Other

I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I also understand this Authorization is subject to revocation/ withdrawal by me at any time by writing to The Woodlands Dermatology Associates, except to the extent the action has already been taken to release this information. This Authorization shall remain valid unless revoked, but will expire one year after signing. I have the right to inspect a copy of the health information to be released, and if I do not sign this Authorization, The Woodlands Dermatology Associates will not release my health information. As a patient or legal representative signing this Authorization, I understand that The Woodlands Dermatology Associates cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/ or alcohol abuse, HIV and mental health treatment.

_____ _____
Signature of patient Date Signature of Parent/Guardian Date

_____ _____
Witness Date Relationship to Patient Date

_____
Physician Approval for Release of Records Date