CLEAR DERMATOLOGY
17556 Katy Freeway Suite G-1
Houston, TX 77094
832-772-3330 (phone)
832-772-3332 (fax)

AUTHORIZATION TO RELEASE/ OBTAIN HEALTH CARE INFORMATION

Patient's Name: _____
(First) (MI) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

I authorize Clear Dermatology to: (**check all that apply**) ☐**Release** or ☐**Obtain** the following information from my medical records:
_____ History & Physical ____ Pathology Results /Slides _____ Operative Reports

_____ Progress Notes _____ Lab Results _____ Other (please specify)

I would like these records: Released to / Obtained from:

Name of Person/ Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: (_____) _____ Fax #: (_____) _____

This authorization covers medical care from: _____ to _____
(date) (date)

The purpose for release of information is:
_____ Personal Use _____Legal Purposes _____ Insurance _____ Medical Care
_____ Social Security/ Disability _____ Other (please explain): _____

I understand that this authorization is valid for **180 days** from the date of signature. I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been made before the receipt of revocation. Additionally, I understand that a fee for preparing and furnishing this information may be charged according to ruling set forth by the Texas State Board of Medical Examiners. Under the Privacy Policy Guidelines, I understand that my authorization for records is not needed in certain situations such as certain situations required by law, records required for treatment, payment and other healthcare operations, and research where there is a limited data set.

Authorization to FAX Medical Records: ☐ Yes ☐ No

_____

Patient Name (print) Patient Signature Date

_____

Parent/Guardian Name (print) Parent/Guardian Signature Date