CLEAR DERMATOLOGY
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AUTHORIZATION TO RELEASE/OBTAIN HEALTH CARE INFORMATION

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

Date of Birth: _____ Phone: _____

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

I authorize Clear Dermatology to ☐**Release** or ☐**Obtain** the following information from my medical records **(select all that apply):**

☐ Visit Notes ☐Pathology Results ☐Lab Results ☐Other (please specify)_____

I would like these records (select one): ☐ 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:
☐Medical Care ☐Personal Use ☐Legal Purposes ☐Insurance
☐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**

_____

If patient under 18: Parent/Guardian Name (print) **Parent/Guardian Signature** **Date**

*Form updated 10/11/18