

TO: Physician Name/Person \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Ph # \_\_\_\_\_ Fax Ph # \_\_\_\_\_

**(Please fill in above physician/person name, address, and telephone number to receive/send medical records)**

Re: **MEDICAL RECORDS RELEASE-Authorization for use and Disclosure of Protected Health Information**

I HEREBY AUTHORIZE:

**Rabin-Greenberg Dermatology**  
7515 S Main St #770  
Houston, Texas 77030  
Office 713-797-6171  
Fax 713-797-6669

**Dermatology Associates of Sugar Land**  
2225 Williams Trace Blvd #112  
Sugar Land, Texas 77478  
Office 281-313-0006  
Fax 281-265-3393

**Kingwood Dermatology**  
2300 Green Oak Dr #200  
Kingwood, Texas 77339  
Office 281-358-7600  
Fax 281-358-1110

To **OBTAIN / RELEASE** (please circle one)

Information from the medical record of:

**PATIENT NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**DOB:** \_\_\_\_\_ **SSN# (LAST FOUR DIGITS)** \_\_\_\_\_

Purpose of disclosure: **Continued Medical Care**

Covering the period of care:  **FROM** \_\_\_\_\_ **TO** \_\_\_\_\_

- ALL RECORDS**
- ALL PATHOLOGY**
- ALL LABS**

I understand that this authorization is for full disclosure of all records including HIV, AIDS, and substance abuse. All information will be disclosed unless you specify information you wish to be excluded.

**Exclusion:** \_\_\_\_\_

The above selected practice and its employees are hereby released from legal responsibility or liability for the release of information contained in the medical record.

I understand that the recipient of this information may re-disclose the information and that the information may no longer be protected by federal HIPPA(Health Insurance Portability and Accountability Act)

I understand this authorization can be revoked at any time, by the person giving authorization by written notice, but it will not apply to any uses or disclosures that occurred before that time.

I have read and understood this consent, specified any exclusion to the release of information, and have signed it voluntarily and of my own free will.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**\*\*ALL HIGHLIGHTED AREAS MUST BE COMPLETED BEFORE WE CAN RELEASE RECORDS**