

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I, the undersigned, do hereby authorize \_\_\_\_\_  
to release information from the medical record of:

\_\_\_\_\_  
Patient Name - Please print

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

to be given to: **Ladera Park Dermatology, P.A.**  
**Janet Dubois, M.D. • Adrienne M. Feasel, M.D.**  
**11671 Jollyville Rd. Ste. 104**  
**Austin, TX 78759**

Information to be released: (Reports may include information on drug/alcohol/psychological/communi-  
cable disease treatment).

- |   |   |
|---|---|
| <input type="checkbox"/> History & Physical       | <input type="checkbox"/> Progress Notes       |
| <input type="checkbox"/> Laboratory               | <input type="checkbox"/> HIV/AIDS information |
| <input type="checkbox"/> Consultation             | <input type="checkbox"/> All of the above     |
| <input type="checkbox"/> Dermatological diagnosis |   |

Reason for releasing information:

- Application for insurance claim or insurance coverage  
 Release to another physician or health professional  
 Worker's Compensation  
 Other \_\_\_\_\_

(Article 4495b, Section 5.08 (j) Texas Revised Civil Statutes require that an authorization for release of  
medical records include 'the reasons or purposes of release').

I understand that I may revoke this consent at any time except to the extent that action has already  
been taken. This authorization expires automatically ninety (90) days from the date of signature.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Reason Patient is unable to sign