AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
FROM
LADERA PARK DERMATOLOGY, P.A.

I, the undersigned, do hereby authorize this practise to release information from the medical record of:

| Patient Name - Please print | Date of Birth | Social Security Number |
|---|---|---|

to be given to: _____
_____
_____
_____

Information to be released: (Reports may include information on drug /alcohol /psychological /communicable diease treatment).

( ) History & Physical
( ) Laboratory
( ) Consultation
( ) Dermatological diagnosis
( ) Progress Notes
( ) HIV/AIDS information
( ) All of the above

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 | |