BLUEBONNET DERMATOLOGY

Authorization for Release of Medical Record Information from or to Bluebonnet Dermatology PLLC

Patient Full Name (If name has changed, please specify)	
Date of Birth	
Street Address	
City / State / Zip	
Home Phone	
Cell Phone	

The above patient or his/her or her parent/legal guardian authorizes Bluebonnet Dermatology, to request or to make a disclosure of medical record information as follows:

___ Send copies of your record to (or discuss information with) the provider/person/facility below

OR

___ Receive copies of your record from (or discuss your information with) the provider/person/facility below.

Name of Provider/Person/Facility: _____

Address: _____

City/State/Zip: _____

Phone: (____)_____ Fax: __(____)_____

Information to be disclosed:
_____Progress Notes
_____Pathology/Lab Report(s)
_____Operative Notes
_____Cosmetic Notes
_____Entire Medical Record

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. There may be a charge for the requested records according to TX State Law. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request to Bluebonnet Dermatology PLLC.

I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I understand copy fees may apply.

Patient/Representative Signature: _____

Date: _____

Parent/Guardian signature required for minor (less than 18 years of age)

Relationship to patient (if other than self): _____

Printed name of Authorized Representative: _____