AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

MEDICAL RECORDS RELEASE

I HEREBY AUTHORIZE:

__RABIN GREENBERG DERMATOLOGY	__KINGWOOD DERMATOLOGY	__DERMATOLOGY ASSOCIATES OF SUGARLAND
7515 S Main St #770	2300 Green Oak Dr #200	2225 Williams Trace Blvd., #112
Houston, Texas 77030	Kingwood Texas 77339	Sugar Land, Texas 77478
Fax # 713-797-6669	Fax# 832-644-8919	Fax # 281-265-3393

To use and disclose protected health information from the record of:

PATIENT NAME: ____

ADDRESS: ____

DATE OF BIRTH: _____________________ SSN# (LAST FOUR DIGITS ONLY) ________

Copies of the following records shall be used and disclosed for Continued Medical Care are:

___COMPLETE CLINICAL RECORDS ___ All ___ Covering the period of care from________ to________

___PATHOLOGY REPORTS ___ All ___ Covering the period of care from________ to ________

___ LABORATORY REPORTS ___ All ___ Covering the period of care from________ to ________

___ FINANCIAL RECORDS ___ All ___ Covering the period of care from________ to ________

I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. All information may be disclosed unless you specify information you wish to be excluded. Exclusions: ______________________________________.

I understand that copies of the records indicated above will be: (check one)

___ SENT TO: Name of Recipient ____

Name of Company ____

Address: ____

City/State/Zip: ____

Phone: ________________________ Fax: ______________________________

___ OBTAINED FROM: Name of Recipient ____

Name of Company ____

Address: ____

City: _________________________ State: ________________ Zip: __________

Phone: ________________________ Fax: ______________________________

___ PICKED UP BY: Name of Recipient ____

Contact Telephone Number ____

I understand that the recipient of this information, as identified above, may not be a "covered entity" under Federal or Texas privacy law and re-disclose the information and that the information may no longer be protected by federal HIPAA (Health Insurance Portability and Accountability Act). I understand 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 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 voluntary and of my own free will.

PATIENT or LEGAL GUARDIAN/REPRESENTATIVE____ DATE____________

PRINTED NAME OF LEGAL GUARDIAN/REPRESENTATIVE (if any) ____

Representative's Authority to Act for Patient_________________________ (LEGAL DOCUMENTS MUST ACCOMPANY THIS REQUEST)