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/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