



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO

Ladera Park Dermatology, P.A.
Janet C. DuBois, M.D. & Adrienne M. Feasel, M.D.
11671 Jollyville Rd ° Ste104 ° Austin, TX 78759
Phone: (512) 345-3599 Fax: (512) 345-3928

I, the undersigned do hereby authorize \_\_\_\_\_(name of Dr. to get records from) to release information from the medical records of:

Patients Name- Please print Date of Birth Social Security Number

To be given to: Ladera Park Dermatology, P.A.
11671 Jollyville Rd ° Ste104 ° Austin, TX 78759
Phone: (512) 345-3599 Fax: (512) 345-3928

Information to be released: (Reports may include information on drug/alcohol/psychological/communicable disease 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 of 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