Ladera Park
DERMATOLOGY, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO

Ladera Park Dermatology, P.A.
Janet C. DuBois, M.D. ◦ Adrienne M. Feasel, M.D. ◦ Brooke Stidham, PA-C
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 | Last Four of SSN

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
- ☐ Pathology
- ☐ 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 one year (365 days) from the date of signature.

_____ _____

Signature of Patient or Authorized Representative | Date

_____ _____

Relationship to Patient | Reason Patient is unable to sign

Office Use Only
Number Faxed to:_____
Faxed by:_____ Date: _____