AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM LADERA PARK DERMATOLOGY, P.A.

I, the undersigned, do hereby authorize this practise to release information from the medical record of:

______________________________	______________	______________________________
Patient Name - Please print	Date of Birth	Social Security Number

to be given to: ______________________________________
____
____
____

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