Ladera Park
DERMATOLOGY, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM

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 this practice to release information from the medical records of:

_____ _____ _____

Patient Name- Please Print | Date of Birth | Last Four of SSN

To be given to: _____

Address: _____

_____

Phone: _____

Fax: _____

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 ninety (90) days from the date of signature.

_____ _____

Signature of Patient or Authorized Representative | Date

_____ _____

Relationship to Patient | Reason Patient is unable to sign