



THE WOODLANDS DERMATOLOGY ASSOCIATES

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Phone: (281) 363 – 5050 Fax: (281) 363-5020

Authorization for Release of Healthcare Information

Patient Name:

Date of Birth:

I hereby authorize the transfer of the following healthcare information:

To: _____

From: The Woodlands Dermatology Associates
9303 Pinecroft Dr, Suite 150
The Woodlands, Tx 77380
Phone: (281) 363-5050 Fax: (281) 363-5020

- Entire contents of chart
- OR** (specify particular portions of chart)
- Progress notes Pathology reports Lab reports
- Correspondence Operative reports
- Purpose of Disclosure: Continuing Patient Care Other

I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrom (AIDS). I also understand this Authorization is subject to revocation / withdrawal by me at any time in writing to The Woodlands Dermatology Associates, except to the extent the action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in one year after signing. I have a right to inspect a copy of the health information to be released, and if I do not sign this Authorization, The Woodlands Dermatology Associates will not release my health information. As the patient or legal representative signing this Authorization, I understand that The Woodlands Dermatology Associates cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and / or alcohol abuse, HIV, and mental health treatment.

Signature of patient Date Signature of Parent/Guardian Date

Witness Date Relationship to Patient Date