



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

From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 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 custodian of medical records in your office, except to the extent the action has already been taken to release this information to The Woodlands Dermatology Associates. 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, your office will not release my health information to The Woodlands Dermatology Associates. Notice is given to The Woodlands Dermatology Associates 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