Spicewood Dermatology, P.A.

EXPERTS IN SKIN HEALTH

Authorization to RECEIVE Patient Information

Patient Name: _____ DOB: _____

I request and authorize information to be RELEASED BY:

Name: _____

Phone/Fax: _____

I request and authorize information to be RECEIVED BY:

Spicewood Dermatology, P.A.
13642 N. Hwy. 183, Bldg. 2, Ste. 100
Austin, TX 78750
(512) 331-7300 / (512) 331-7318

Reason for Release:

O Continued care
O Attorney
O Disability
O Other _____
O School
O Insurance
O Personal

Information Requested:

O Complete record
O Pathology results
O Lab results
O Other _____

I understand and agree that the information I am authorizing to be released may include: 1. AIDS/HIV test results, diagnosis, treatment and related information; 2. Drug screen results and information about drug and alcohol use and treatment; 3. Mental health information; and/or 4. Genetics testing (Unless otherwise requested)

I further understand that this Authorization is voluntary and I may refuse to sign this Authorization. I understand that I may revoke this Authorization at any time by notifying Spicewood Dermatology, P.A. (or the releasing facility) in writing. I understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so, e.g, payment for copy costs. I understand that I may refer to Spicewood Dermatology, P.A.s' Notice of Privacy Practices.

RELEASE FROM LIABILITY: I release and agree to hold harmless Spicewood Dermatology and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand Spicewood Dermatology cannot be responsible for use or redisclosure of information by third parties.

TO THE RECEIVING PARTY OF THIS INFORMATION This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulations.

If the healthcare services (including examination and drug screening) are being paid for by my employer (or prospective employer), I understand and agree that all records and information related to the healthcare services provided to me may be given directly to my employer and if I wish to obtain such information, I should contact my employer/prospective employee.

I certify that this form has been fully explained to me, that I have read it or had it read to me* and that I understand its contents.

_____ _____
Patient / Other Legally Authorized Person Date

_____ _____
Witness / Translator* Relationship to Patient