EPIPHANY DERMATOLOGY

6601 Vaught Ranch Rd, Ste 200
Austin, TX 78730
Phone: (512) 628-0465
Fax: (512) 628-0468

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name (as it appears on DL/State ID): Date of Birth: [DOB]_____/_____/_____

_____

I request and authorize **Epiphany Dermatology** to release healthcare information of the patient named above to:

Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

Please send copies of the following Medical Records (check all that apply):

___ Office Consult notes ___ Pathology report(s) ___ Lab report(s)

___ Entire Medical Records

___Other:_____

I understand the following:
I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations.

I understand that the healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may refuse to sign this authorization

Patient/Guardian Signature: _____ Date:_____

Exp Date (One year from date of request): _____