



**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_

I request and authorize: Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

to release healthcare information of the patient named above to:

**Memorial Dermatology  
915 Gessner, Suite 950  
Houston, TX 77024  
Phone: (713) 468-2200 Fax: (713) 468-2213**

This request and authorization applies to:

All healthcare information

Healthcare information relating to the following treatment, condition or dates: \_\_\_\_\_

X-Rays     Laboratory/Pathology Reports     Progress Notes     Other \_\_\_\_\_

Yes     No    I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person (s) listed above. I understand that the person (s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes     No    I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person (s) listed above.

This authorization shall be valid for 120 days from date of signature. The patient can revoke the authorization in writing at any time prior to expiration date. The patient agrees that a photocopy of this authorization may be considered valid. The patient understands that when this information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above name facility from all liability and damage resulting from the lawful release of my Protected Health Information.

\_\_\_\_\_  
Patient or Authorized Legal Representative Signature

\_\_\_\_\_  
Date