Authorization to Release Healthcare Information

ALL PATIENT RECORDS AND/OR RELEASES SHOULD BE EMAILED TO
ClinicalTeam@ClearLakeDerm.Com

Patient name: _____ Previous name (if applicable) _____

Date of birth _____ Phone number: _____

Address: _____

City/State/Zip: _____

Please check one of the following options:

- ☐ I would like my records from another physician's office sent to Clear Lake Dermatology
- ☐ I would like my records to be sent from Clear Lake Dermatology to a different physician's office
- ☐ I would like a copy of my medical records for personal use

Provider's name _____ Specialty _____

Address: _____ Phone Number: _____

City/State/Zip: _____ Fax Number: _____

This request authorization applies to (select one):

- ☐ All healthcare information
- ☐ Healthcare information relating to the following treatment only _____
- ☐ Other _____

Information is needed for:

_____ Continued Care _____ Personal Use _____ Insurance _____ Legal _____Other

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but not be limited to, history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Patient signature: _____ Date: _____

13938 Highway 3
Unit 100
Webster, TX 77598
281.332.9681 (p)
281.332.5957 (f)

2508 Gulf Freeway S.
Suite 110
League City, TX 77573
281.310.5881 (p)
281.332.5957 (f)