SOUTHEAST DERMATOLOGY, P.A.

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ALL PHYSICIANS ARE BOARD CERTIFIED IN DERMATOLOGY

** AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION **

PATIENT INFORMATION:

NAME:	**D.O.B.**
ADDRESS:	

**** I HEARBY REQUEST AND AUTHORIZE *SOUTHEAST DERMATOLOGY, P.A.* TO OBTAIN OR RELEASE COPIES OF MY MEDICAL RECORDS ****

☐ **OBTAIN**
☐ **RELEASE**
(PLEASE SELECT ONE)

PHYSICIAN / FACILITY INFORMATION:

NAME:	**ADDRESS:**
PHONE:	
FAX:	

****** THIS AUTHORIZATION APPLIES TO ALL OF THE RECORDS INDICATED BELOW:** (PLEASE CHECK ALL THAT APPLY)

☐ COMPLETE MEDICAL RECORDS
☐ LAB RESULT(S)
☐ BIOPSY REPORT(S)
☐ OTHER: _____

FOR DATES OF SERVICE FROM _____ **TO** _____

THE PURPOSE OF THIS REQUEST IS:

☐ **AT THE REQUEST OF THE INDIVIDUAL**
☐ **CONTINUITY OF CARE**

When requesting medical records please allow at least five business days. There will be a **$25.00** processing fee unless the request is from physician to physician or otherwise stated.

_____ _____
Patient Signature Date

_____ _____
Witness Date

This authorization will remain valid for 1 year from the date of signature.

4419 Crenshaw Rd. Pasadena, TX 77504
Tel – (281) 991-5944 x 137 **|** **Fax** – (281) 991-1136