Authorization for Use or Disclosure of Medical Records

Patient Information:

Patient Name: _____ DOB: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell / Work Phone: _____

Release Information To (check one):

- ☐ *I hereby authorize Tricia Brown, M.D. to release my medical record information **to another physician** or facility listed below.*
- ☐ *I hereby authorize the physician or facility listed below to release my medical information **to Tricia Brown, M.D.***

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Delivery Preference (check one):

- ☐ Mail/fax copies to address listed above
- ☐ Hold for patient pick-up

Information to Be Released (check one):

- ☐ Progress notes only
- ☐ Laboratory notes only
- ☐ Pathology reports only
- ☐ All records
- ☐ Other (specify records needed): _____

Purpose for Need or Disclosure (check one):

Article 449b, Section 5.08(J) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reason or purpose for the release."

- ☐ Continued patient care
- ☐ Insurance claim/ application
- ☐ Attorney/ legal
- ☐ Change of physician/ relocation
- ☐ Other:

_____

I understand that the information released is for the specific purpose stated above. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.

_____ _____ _____

Signature of Patient or Guardian | Relationship to Patient (if parent or guardian) | Date

Please fax completed form to (281) 477-0004 or mail to address below.

Tricia Brown, M.D. Dermatology | 18220 State Highway 249, Ste 270 | Houston, TX 77070 | Phone 281-477-0003 | Fax 281-477-0004