Central Austin Dermatology, PA
Jay A. Hendrix, MD Shirien O. Coover, PA-C
720 W 34th St, Ste 210, Austin, TX 78705
(512) 450-1001 fax (512) 302-9723

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB _____ SSN _____

Address _____

I authorize and request that a copy of the following information from my medical record be released as follows:

From: _____ **To: _____**

_____ _____

_____ _____

_____ _____

Information to be Released

___ Office Notes **___ Medication Records**
___ Lab Reports **___ X-ray Reports**
___ Pathology Reports
___ Operative Notes **___ Other:**

Including Information (if applicable) pertaining to:

___ Psychiatry/Psychology **___ HIV/AIDS** **___ Alcohol/Drug Use**

Purpose of disclosure:

___ Continuing Medical Care **___ Attorney**
___ Personal Use **___ Worker's Compensation**
___ Commercial Insurance **___ Other:**

I understand that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person. I understand that my medical record may contain information that only a physician can interpret. I understand and have been advised that I should contact my physician with any questions about information contained in my medical record.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to patient Witness