Authorization for Release of Healthcare Information

Patient Name: _____Date of Birth: _____

I hereby authorize the transfer of the following healthcare information:

○ **TO:** **DeSilva Dermatology**
120 Old San Antonio Road
Boerne, TX 78006
Phone: 830-331-4150
Fax: 830-310-6378
Fr: Dr. Practice Name:
_____
Phone: _____
Fax: _____

○ **From:** **DeSilva Dermatology**
120 Old San Antonio Road
Boerne, TX 78006
Phone: 830-331-4150
Fax: 830-310-6378
To: Dr. Practice Name:
_____
Phone: _____
Fax: _____

To Release:
☐Entire contents of chart **OR** ☐Progress Notes & Path ☐Labs ☐Specific _____

Purpose of Disclosure ☐ Continuing Patient Care ☐ Other

I understand the specific information to be released may include, but not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illness, or communicable disease, including human immunodeficiency virus (HIV) AND Acquired Immune Deficiency Syndrome (AIDS). I also understand this Authorization is subject to revocation/withdrawal by me at any time by writing to DeSilva Dermatology, except to the extent that action has already been taken to release the information. As a parent or legal representative signing this authorization, I do understand that DeSilva Dermatology cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others.

SIGNATURE: _____Date: _____
Signature of Individual or Individual's Legally Authorized Representative
Print Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐Parent ☐Guardian ☐Other _____