MEDICAL RECORDS RELEASE

DATE:________________________

PATIENT NAME: ____________________________________ DOB: ______________________

ADDRESS: ____

____

CITY STATE ZIP

RECORDS RELEASE TO:

Patient/Physician

Name:____________________________________

Address: __________________________________

City/State/Zip: ______________________________

Phone: ____________________________________

Fax: ______________________________________

Appointment Date: ___________________________

RECORDS RELEASED BY:

JUNIPER

DERMATOLOGY

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3801 N Capital of Texas Hwy, Suite J225
Austin, Texas 78746
www.juniperderm.com

By signing below, I authorize Juniper Dermatology to disclose and/or release certain protected health information (PHI) to the recipient.

______ Complete medical records _______ Lab Reports Other________________________________

This authorization covers care provided from date __________________ to date __________________________

Purpose of disclosure ____

I understand that the following information released is for the specific purpose stated above and that there is a **$25 processing fee** for this service. Any other use of this information without written consent of the patient or legal representative is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

____ ___________________________

Signature of Patient or Patient's Legal Representative Date
(Please attach supporting documentation for legal representative)