MEDICAL RECORDS RELEASE

DATE:_____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

_____

CITY STATE ZIP

RECORDS RELEASED FROM:

Name:_____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

RECORDS RELEASED TO:

JUNIPER
DERMATOLOGY
Tel 512-808-4777 Fax 512-808-4779
3801 N Capital of Texas Hwy, Suite J225
Austin, Texas 78746
www.juniperderm.com

By signing below, I authorize the above institution to disclose and/or release certain protected health information (PHI) to the recipient. My signature permits a release of the following identifiable health information about me to Juniper Dermatology.

_____ Histopathology reports _____ Lab Reports Other_____

This authorization covers care provided from date _____ to date _____

Purpose of disclosure _____Continuation of Care_____

I understand that the following information released is for the specific purpose stated above. 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 180 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)