Ladera Park
DERMATOLOGY, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM

Ladera Park Dermatology, P.A.
◦ Adrienne M. Feasel, M.D. ◦ Brooke Stidham, PA-C
11671 Jollyville Rd ◦ Ste104 ◦ Austin, TX 78759
Phone: (512) 345-3599 Fax: (512) 345-3928

I, the undersigned, do hereby authorize this practice to release information from the medical records of:

Patient Name - Please Print	Date of Birth	Last Four of SSN

To be given to: _____

Address: _____

_____

Phone: _____

Fax: _____

Information to be released: (Reports may include information on drug/alcohol /psychological /communicable disease treatment).

- ☐ History & Physical
- ☐ Laboratory
- ☐ Pathology
- ☐ Consultation
- ☐ Dermatological Diagnosis
- ☐ Progress Notes
- ☐ HIV/AIDS Information
- ☐ All of the above

Reason for releasing information:

- ☐ Application for insurance claim or insurance coverage
- ☒ Release to another physician or health professional
- ☐ Worker's Compensation
- ☐ Other _____

(Article 4495b, Section 5.08(j) Texas revised Civil Statutes require that an authorization for release of medical records include the reasons of purposes of release)

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This authorization expires automatically ninety (90) days from the date of signature.

Signature of Patient or Authorized Representative	Date
Relationship to Patient	Reason Patient is unable to sign