Liberty Dermatology

7105 Lakeview Pkwy, Ste 100
Rowlett, TX 75088
Ph: (972) 475-5300
Fax: (972) 695-8410

AUTHORIZATION TO DISCLOSE PROTECTED INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize _____to disclose my protected health information. Please check an item or items below.

Last 3 office visit notes: _____ First office visit note: _____ Pathology Report: _____
Lab Report: _____ Other:_____
Records of care from _____ to _____ only

☐ **Send to Liberty Dermatology**
Liberty Dermatology
7105 Lakeview Pkwy, Suite 100
Rowlett, TX 75088
Phone: 972-475-5300
Fax: 972-695-8410

☐ **Send to the following recipient**
Name: _____
Address: _____
City: _____
Phone: _____
Fax: _____

The reasons or purposes of this release of information are as follows:_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. *I understand I may be charged a Retrieval/Processing Fee and for copies of my medical records from the custodian of my records.* This authorization will expire one year from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:_____

I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under the Federal or Texas privacy laws, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient, and, therefore, may be subject to re-disclosure by the recipient. I understand that according to Chapter 159 of the Texas Occupational Code Section 159.005 (e) and HIPPAA, a re-disclosure could be made from records received from another health care provider involved in my care or treatment.

Signed: _____ Date: _____

Print: _____
Name of Patient (or person legally authorized to consent on patient's behalf)