# Authorization for Transfer of Medical Records to Dr. Brown

Patient Information:

Patient Name: _____ DOB: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell / Work Phone: _____

Date of Request: _____

*I hereby authorize the physician or facility listed below to release my medical information* ***to Tricia Brown MD - Dermatology.***

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Delivery Preference: Please fax/mail copies to office address listed below:

Tricia Brown MD - Dermatology
10845 Kuykendahl Rd, Ste 103
The Woodlands, TX 77382

Phone: 832-871-4111
Fax: 832-871-4112
Email: staff@yourclearskin.com

Information to Be Released (check one):

- ☐ Progress notes only
- ☐ Laboratory notes only
- ☐ Pathology reports only
- ☐ All records
- ☐ Other (specify records needed): _____

Purpose for Need or Disclosure (check one):

*Article 449b, Section 5.08(J) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reason or purpose for the release."*

- ☐ Continued patient care
- ☐ Insurance claim/ application
- ☐ Attorney/ legal
- ☐ Change of physician/ relocation
- ☐ Other: _____

*I understand that the information released is for the specific purpose stated above. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.*

_____ _____ _____

Signature of Patient or Guardian | Relationship to Patient (if parent or guardian) | Date