Authorization for Transfer of Medical Records To Another Location/ Self

Patient Information:

Patient Name: _____ DOB: _____

Address: _____ Home Phone: _____

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

I hereby authorize Tricia Brown, M.D. to release my medical record information ***to another physician/facility or to myself*** *listed below.*

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

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

Delivery Preference (check one):

- ☐ Fax copies to address listed above
- ☐ Hold for patient pick-up

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

Please fax completed form to (832) 871-4112 or email / mail to address 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

* Our office does not charge to transfer medical records directly to another physician for continued patient care. Medical record copies for patient/personal use are subject to a minimal fee as legislated by the state of Texas.