Mary Ann Martinez, M.D. at Bee Caves Dermatology, 5656 Bee Cave Road, Bldg. D, Ste203 Austin, TX 78746, Phone 512-329-6090 Fax 512-329-0125

Authorization for Use or Disclosure of Medical Record Information

Patient Information

Patient Full Name: ______________________________ *Date of Birth:* ______________

Patient Address: ______________________________ *Home Phone:* ______________

City: ________________ *State:* ________ *Zip:* ________ *Work Phone:* ______________

Release Information To

☐*I hereby Authorize Bee Caves Dermatology to release my medical record information to*

☐*I hereby Authorize the Physician or Facility listed below to release my medical information to Bee Caves Dermatology, the office of Mary Ann Martinez, M.D.*

Mail/Fax Copies To: *Hold for Patient Pick-up* *Discuss Medical Information With:*

Name/Facility: ______________________________ *Attention:* ______________________________

Address: ______________________________ *Phone:* ______________________________

City: ________________ *State:* ________ *Zip:* ________ *Fax:* ______________________________

Information to be Released

☐*Progress Notes* ☐*Laboratory Reports* ☐*Pathology Reports*

Specific Records Needed: ____

Bee Caves Dermatology does not provide copies of records received for another physician or institution. Please request these records directly from the original healthcare provider.

Purpose for Need or Disclosure - (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*

There is a charge of $25.00 for the first 20 pages and 50 cents per page for every copy thereafter. In addition, you may be charged a reasonable administrative fee covering actual costs for mailing, shipping, or delivery. I understand that the information released is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Bee Caves Dermatology liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. 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 90 days after the date of my signature unless other wised specified.

______________________________ ______________________________

Signature of Patient or Legal Guardian Date

______________________________ ______________________________

Relationship to Patient (self, parent, spouse) Witness Signature

*****please confirm you have completed ALL protected information categories above regardless if they are applicable or not. If form is incomplete we will be unable to fulfill your request*****