BAYOU CITY
DERMATOLOGY

Dr. Karan Sra, M.D., FAAD

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
to Bayou City Dermatology from another physician/facility

I hereby authorize:

Name/Facility: _____

Address:_____

Phone: _____ Fax: _____

To release to:

Name/Facility: Bayou City Dermatology

Address: 202 N. Texas Ave Suite 300

Phone: 346-406-1846 Fax: 346-406-1786

The information from the hospital/clinic medical records on:

Patient Name:_____DOB:_____

Patient Address:_____

Admit/Treatment Date(s) (if known) :_____SSN:_____

I hereby authorize the release of the following information, including if applicable, any treatment or test results for alcohol and/or drug abuse, or reportable communicable diseases, including acquired immune deficiency syndrome (AIDS) or human immuno-deficiency virus infection (HIV).

___ All ___ Treatment/Progress Notes ___ Laboratory ___ Xray ___ Biopsy Results

The above information is requested for the following purpose and that purpose only: Patient is being treated at this clinic.

I understand that I may revoke, in writing, this authorization at any time, but not retroactive to the release of information made in good faith.

This authorization will expire one year from the date of my signature or as otherwise specified by date, event or condition as follows:_____

_____ _____
Patient Signature Date

I hereby consent on his/her behalf and in his/her stead.

_____ _____ _____
Signature of Legal Representative Print Name Date