

Four Points Dermatology
Roopal Bhatt, M.D.
6618 Sitio Del Rio Blvd, Ste D101
Austin, TX 78730
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RELEASE OF RECORDS

Patient Name _____ Date of Birth _____

SSN _____ Phone # _____

Release records:

- To Four Points Dermatology
 From 6618 Sitio Del Rio Blvd
Suite D101
Austin, TX 78730

Release records:

- To _____
 From _____
- Name/Organization _____
- Address _____
- City/State _____ Zip _____
- Phone# _____ Fax# _____

Records to release:

- Complete record
 Lab reports
 Progress notes
 Specific portion
Specify: _____
 Other

Reason to release:

- Consultation
 Continue medical care
 Personal
 Insurance
 Other

Method of Release:

- Call me when records are ready
to pick-up Ph# _____
 Mail records to address above
 Please fax my records

I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, 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 this authorization is valid for six months unless I notify Four Points Dermatology (FPD) otherwise. I may revoke this authorization in writing at any time except to the extent that FPD has already relied on this authorization. I may revoke it by mailing or faxing a written notice to FPD to the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form.

Signature of Patient/Responsible Party

Date Signed