HOUSTON DERMATOLOGY SPECIALISTS
Medical | Cosmetic | Mohs Surgery

HIPAA Release

What is your preferred contact number?

☐ Home _____ ☐ Work _____ ☐ Cell _____

I hereby grant Houston Dermatology Specialists permission to notify me by telephone of the following:

☐ Message to call the office for test results (the actual results will not be left).
☐ If the results are benign, a message will be left stating no further treatment will be needed and to keep any advised follow-up as recommended by your physician.

I hereby authorize Houston Dermatology Specialists to disclose my personal medical information pertaining to my diagnosis and/or treatment, biopsy results, medical history, or any other information to myself and those listed below.

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Assisted Living/Long-Term Care Facility Patient: Please list any facility personnel that we are allowed to speak with on your behalf regarding your medical information.

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Do you have a Power of Attorney: ☐ Yes ☐ No (If yes, please list below)

Name: _____ Phone: (___)_____

(If yes, please include a copy of the Power of Attorney paperwork to Houston Dermatology Specialists)

All Patients: The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize the release of this information to other healthcare providers associated with my care to facilitate other healthcare treatment. I further understand that records for medical information from persons not listed above will require specific authorization prior to disclosure of my medical information.

Signature: _____ **Date:** _____

Printed Name: _____

(Parent/guardian authorizes and signs on behalf of _____ (**name of minor**)