MEDICAL RECORDS RELEASE FORM AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name	**Date of Birth**	**Today's Date**	
Patient Address	**City**	**State**	**Zip Code**
Phone	**Alt Phone**		

I authorize the following to disclose the patient's protected health information:	The provider/office listed below will receive and use the health information:
Connie Wang MD – Elite Dermatology Office/Provider Name	 Office/Provider Name
(281) 612 - 0050 Phone	( ) Phone
(281) 612 - 0051 Fax	( ) Fax
4603 FM 1463 Suite 100 Office Address	 Office Address
Katy TX 77494 City State Zip	 City State Zip

The following information shall be disclosed:

- ❑ All records
- ❑ Laboratory/pathology records only
- ❑ Other (describe specifically) ____

Note: *If these records contain any information from previous providers or information about cancer diagnosis or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

*****This authorization shall expire 180 days after the date of signature.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

____ ____________________________

Signature of patient (or patient's personal representative) Date

____ ____________________________

Witness Date