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