ELECT DERMATOLOGY FACSIMILE TRANSMITTAL SHEET

TO:
Dermatology Associates of San Antonio

FAX NUMBER OF RECIPIENT: 210 293 1840

TOTAL NUMBER OF PAGES SENT:

FROM:
ELECT DERMATOLOGY
2154 Gabriel's Place
Suite 103
New Braunfels Texas 78130
Phone 833-353-2875
Fax 833-518-3378

DATE

COMMENTS:
Please fax the requested medical records to Elect Dermatology at the above fax number

Elect Dermatology

2154 Gabriel's Place Suite 103, New Braunfels Texas 78130
Phone (833)-353-2875 Fax (833) 518-3378
AUTHORIZATION TO OBTAIN CONFIDENTIAL MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Patient Address _____

Patient Phone Number _____

Patient Maiden Name or Name Used on Medical record _____

I authorize Elect Dermatology to obtain information from:

Name of facility or provider DERMATOLOGY ASSOCIATES OF SAN ANTONIO

Address 7832 PAT BOOKER ROAD SAN ANTONIO TEXAS 78233

Phone # (w/ area code) 210-657-9338 Fax number (w/ area code) 210-293-1840

Information regarding person or entity who can receive and use this information:

TO: Dr. Alfred Hockley III or Dr. Stephen Stahr ELECT DERMATOLOGY
Current mailing address: PO Box 9 Converse Texas 78109
Phone 833 - 353- 2875 Fax 833-518-3378

Specific information to be disclosed:

__ Medical records from (insert date) _____ to (insert date) _____

X Entire Medical Record including patient histories, office notes, lab results, and pathology report

__ Specific Records _____

Reason for release of information:

X Treatment/continuing care __ Other _____

The individual signing this form agrees and acknowledges as follows:

(i) Voluntary authorization: This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing of this form.
(ii) Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the healthcare provider/entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taking using this authorization
(iii) Signature Authorizarion: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission

Signatures

Patient/Legal Representative _____ Relationship to patient _____

Date _____