Request for Release and Disclosure of Patient Information

I hereby request and authorize the office of Sonterra Dermatology to release copies of my medical records to: _____ (**Fax Number**): _____

Sonterra Dermatology, PLLC
Annabelle L. Garcia, MD / Allison Metzinger, MD / Milton Moore, MD
Edward Keuer, MD / James Neiner, MD / Justin Bandino, MD
Daniella Arellano, PA-C / Teagan Charles, PA-C
1314 E Sonterra Blvd. Building 2, Suite 2201, San Antonio, TX 78258
Phone: (210) 496-5792 Fax: (210) 496-7601

This authorization applies to all of the reports checked below:

_____ Complete Chart

_____ X-Ray Reports

_____ History and Physical Examinations

_____ Laboratory Reports

_____ Progress Notes and Care Plans

_____ Other: _____

Purpose of disclosure: (check all that apply)

_____ Medical Care _____Transfer Records _____Other

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM THE DATE OF YOUR SIGNATURE BELOW.

Prohibition of Re-disclosure

Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains.

I understand that, as set forth in the provider's HIPPA Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Sonterra Dermatology
1314 E. Sonterra Blvd, Building 2, Suite 2201
San Antonio, TX,78258

I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy my protected health information to be used or disclosed as permitted under the federal law (or state law to the extent the state law provides greater access rights).

_____ _____

Name of Patient or Personal Representative (**please print**) Description of Personal Representative's Authority

_____ _____ _____

Signature of Patient or Personal Representative Patient's Date of Birth Date