Keller Dermatology, P.A.

Authorization to Release Medical Information

I, _____ hereby authorize
(Name of patient or legal representative)

_____
(Name of person/entity who should release records)

_____
(Address of person/entity who should release records)

to release the following information by mail, fax, electronically, or orally to:

Keller Dermatology, P.A.
Jack B. Cohen, D.O.
601 S. Main St., Suite 115
Keller, TX 76248
Telephone: 817-753-6633 Fax: 817-753-6634
E-mail: info@kellerdermatology.com

From the health records of:

For the purpose of:

- ☐ **ALL RECORDS**
- ☐ Statements of charges or payments
- ☐ Records of all visits
- ☐ AIDS or HIV information
- ☐ History and Physical Examination
- ☐ Record of visit for a specific date(s)
- ☐ Specific dates include or are limited to: _____
- ☐ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)
- ☐ Mental health and/or alcohol and drug abuse treatment
- ☐ Other (must be specific): _____
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Hepatitis Information
- ☐ Photographs, videotapes, digital, or other images

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization is as valid as this original.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. Keller Dermatology, P.A., it's employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.
6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient's Printed Name Date of Birth

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

_____
Relationship to Patient