**Isabella Gyening, MD**
**1920 Country Place Parkway Suite 310**
**Pearland, Texas 77584**
**281-902-1026**
**Fax 713-340-1725**

# Authorization for Release of Healthcare Information

Patient Name: _____

Date of Birth: _____

**I hereby authorize the transfer of the following healthcare information**:

To: _____

_____

_____

_____

From: Family Dermatology & Skincare Center
Isabella Gyening, MD
1920 Country Place Parkway #310
Pearland, TX 77584

☐ Entire Contents of Chart

OR(specify specific parts of the chart)

☐ Progress Notes ☐ Pathology Reports ☐ Lab Reports ☐ Correspondence

Purpose of Disclosure: ☐ Continuing Patient Care ☐ Other_____

I understand that specific information to be released may include, but is not limited to history, diagnosis and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The revocation must be in writing and delivered to Family Dermatology & Skincare Center. It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

I understand that the Family Dermatology & Skincare Center associates cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Family Dermatology & Skincare Center, its employees and partners and provider are released from the legal responsibility for the release of the above information to the extent indicated and authorized herein.

**This consent will expire 180 Days After Date of Signature**

_____ _____
Signature of Patient Date Signature of Patient's Representative Date

_____ _____
Witness Date Relationship to Patient



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