Bellaire Dermatopathology Laboratory
6565 West Loop South, Suite 800
Bellaire, Texas 77401
713-661-4383 Fax 713-661-4346 (fax)

AUTHORIZATION TO RELEASE/ OBTAIN HEALTH CARE INFORMATION

Patient's Name: _____
(First) (MI) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

I authorize: ☐ Howard B. Gerber, MD ☐ Craig F. Teller, MD ☐ Suneel Chilukuri, MD
☐ Kimberly Mullinax, MD ☐ Jennifer L. Maender, MD ☐ Rebecca G. Clark, MS, PA-C
to (**please check action**): ☐ **Release** or ☐ **Obtain**

the following information from my medical records **to** or **from (circle one)**:

Name of Person/ Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: (_____) _____ Fax #: (_____) _____

Please check all information to be released (may contain information regarding drug/ alcohol/ psychological/ HIV/ AIDS and/ or communicable diseases):

_____ History & Physical ____**Pathology Results / Slides** _____ Operative Reports

_____ Progress Notes _____ Lab Results _____ Other (please specify) _____

This authorization covers medical care from: _____ to _____
(date) (date)

The purpose for release of information is:

_____ Personal Use _____Legal Purposes _____ Insurance _____ Medical Care

_____ Social Security/ Disability _____ Other (please explain): _____

I understand that this authorization is valid for **180 days** from the date of signature. I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been made before the receipt of revocation. Additionally, I understand that a fee for preparing and furnishing this information may be charged according to ruling set forth by the Texas State Board of Medical Examiners.

Authorization to FAX medical records: ☐ Yes ☐ No

_____ _____ _____ _____
Signature of Patient Date Signature of Parent/ Executor/ Legal Representative Date

_____ PHONE