Dr. Kelly Duncan
Dr. Sherry Ingraham
Dr. Adaeze Egesi
Dr. Sangeetha Venkatarajan
Dr. Michael Pelster
Dr. Alexander Marzuka

PA-C Toni Smith
PA-C Kendra Salazar
PA-C Piipar Rivera
PA-C Shayla Arceneaux

For Patient Use Only - Physicians should fax their request or email to:
medicalrecordsrequest@advdermtx.com

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

For: _____
Patient Name/DOB

Fax form to 1-833-516-4366

Release To: _____

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

Phone: _____ Fax: _____

I herby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained from the following:

- ☐ 430 S. Mason Rd., Suite 101 / Katy, Texas 77450
- ☐ 2950 Cullen Parkway, Suite 102 / Pearland, TX 77584
- ☐ 1235 Lake Pointe Pkwy, Suite 200 / Sugar Land, Texas 77478
- ☐

Information authorized for use of disclosure or to be obtained:

Labs (Bloodwork, Biopsy, Culture) on: _____ **<Date of visit**
Date

Most Recent Offcie Visit on: _____ **<Date of visit**
Date

Records between date range: _____ **to** _____
Begin Date End Date

Special Request [write in]: _____

This information will be obtained, used, or disclosed for the following purpose(s) only:

- ☐ Insurance
- ☐ Continued Treatment
- ☐ Legal
- ☐ Request of Patient/Patient's Representative
- ☐ Other [please specify] _____

I understand:

- This request will be valid for 1 year unless revoked in writing.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and may refuse to sign this authorization.

NOTE: There are charges that apply to all Medical Records release requests.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric or substance abuse.

_____ _____
Signature of Patient/Patient's Representative Date

_____ _____
Authority of Patient's Representative Expiration Date of Authorization