

# OCHS DERMATOLOGY

ROBERT OCHS, MD

**Authorization for Release of Medical Records**  
***Please complete all sections. Print clearly.***

Patient Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Release Records To:

Provider/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Records to Release (check as applicable):

Complete Medical Record

Office Notes

Lab Results

Procedures

Other: \_\_\_\_\_

Purpose of Disclosure:

Continuing Care  Personal Use  Insurance  Other: \_\_\_\_\_

Special Consent for HIV/AIDS Records

I authorize the release of my HIV/AIDS-related medical information.

Patient Initials: \_\_\_\_\_

14855 Blanco Road, Ste 214  
San Antonio, TX 78216  
210-493-1568 PHONE 210-493-8345 FAX

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## Authorization for Release of Medical Records

*Please complete all sections. Print clearly.*

### Authorization

By signing this form, I authorize Ochs Dermatology to release confidential health information about me, including copies of my medical records, summaries, or narratives of my protected health information (PHI), to the person(s) or entity listed above.

I understand this authorization is voluntary and may be revoked in writing at any time, except to the extent records have already been released. I also understand the information may be subject to re-disclosure by the recipient.

### Acknowledgment of Timeline and Fees

I understand that Ochs Dermatology will provide this information within 15 days of receipt of this request and that a fee for preparing and furnishing this information may be charged in accordance with rulings set forth by the Texas State Board of Medical Examiners.

Expiration: One year from date of signature unless otherwise specified: \_\_\_\_\_

Signature

Patient/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by representative: Name/Relationship: \_\_\_\_\_

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