Authorization of Releasing Information

Authorization to release or use information for treatment, payment, or health care operations.

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by The Skin Clinics of Texas to carry out treatment, payment, or any health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information. You have the right to review such notice prior to signing this consent form.

We reserve the right to change the terms of it's Notice of Privacy Practices at any time. If we do make changes to the terms of it's Notice of Privacy Practices, you may obtain a copy of the revised notice by contacting our office.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the practice.

I agree and consent to releasing information to me in the following manners;

Via Mail ☐ Okay to Mail to Home Address	**Please Initial**
Via Home Phone ☐ Okay to Leave a Detailed Message	
Via Cell Phone ☐ Okay to Leave a Detailed Message	

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured/Guardian:	**Date:**