REVELUS Dermatology

AUTHORIZATION TO RELEASE MEDICAL RECORDS

AUTHORIZATION

By signing this document, I authorize the release of my medical records as detailed below. I acknowledge that certain medical information is best interpreted by a physician. I further recognize that interpretations made without a physician's guidance will not render Revelus Dermatology or its health care professionals liable. This authorization is valid for one year from the signing date and can only be revoked in writing.

PROCESSING & HANDLING FEES *(does not apply if Revelus is acquiring records on your behalf)*

A processing & handling fee is associated with all record release requests. For records dispatched to patients, physicians, or medical facilities, a flat fee of $6.50 applies. In cases of extensive record releases, the fee is $6.50 plus any additional production, postage, and staff time costs. Record releases to non-medical entities carry a $25.00 flat fee, with an additional $0.50 per page after the first 20 pages. We will contact you when payment is required. Fee inquiries for unique cases welcome. Remember, established patients can access their records at no charge via the EMR portal accessible at revelusdermatology.com.

PATIENT INFORMATION

First Name _____ Last Name _____ DOB _____

Cell Phone _____ Home Phone _____

I AUTHORIZE THE RELEASE OF INFORMATION: *(select one)*

☐ **To Another Party**: I am a patient at Revelus Dermatology. I am submitting a request for Revelus Dermatology to release medical records to the 3rd Party Physician or Facility listed below.

☐ **To Revelus Dermatology**: I am a patient at Revelus Dermatology or intend to become one. I am submitting a request for Revelus Dermatology to acquire medical records from the 3rd Party Physician or Facility listed below.

☐ **Dr. Epstein Patient** (To Another Party): I am a prior Dr. Epstein patient and have not been seen by Revelus Dermatology. I am submitting a request to release my paper medical records to the 3rd Party Physician or Facility listed below. Records will be digitized and provided "as-is".

3RD PARTY PHYSICIAN OR FACILITY CONTACT INFORMATION

Name _____ Street Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Special Notes _____

REVELUS DERMATOLOGY CONTACT INFORMATION

Mailing Address
Revelus Dermatology
2559 Western Trails Blvd, Ste 301
Austin TX, 78745

Medical Records Fax:
(512) 318-2538

Phone:
(512) 815-2559

DELIVERY METHOD: *(skip this section if Revelus Dermatology is acquiring your records)*

☐ Mailed to 3rd Party ☐ Secure e-Mail _____ ☐ Fax _____

☐ Individual _____ Individual's Phone _____

SIGNATURE

I understand that my signature below confirms that I have read, understand, and consent to the authorization to obtain or release of medical records as directed above.

_____ _____ _____

Patient, Guardian, or Responsible Individual Signature | Patient Name | Date