REVELUS Dermatology

AUTHORIZATION TO RELEASE OR ACQUIRE PROTECTED HEALTH INFORMATION

INTRODUCTION

This form is required for all Protected Health Information (PHI) records requests through Revelus Dermatology. While obtaining records from other parties is free, release fees vary by recipient: $6.50 for standard patient or physician transfers, $25.00 for third parties or custodial records. Extensive releases requiring printing or faxing incur additional per-page charges. Established patients can access their records free through the EMR Portal. For complete fee details or special circumstances (disability claims, outside forms, letters), visit revelus.to/mr or scan the QR code.

PATIENT INFORMATION

First Name _____ Last Name _____ DOB _____

Cell Phone _____ Home Phone _____

I AUTHORIZE REVELUS DERMATOLOGY TO *(select one)*

☐ Release my PHI ☐ Obtain my PHI

I am a patient at Revelus Dermatology and authorize the release of my PHI to the 3rd party, physician, or facility listed below. Processing & handling fees may apply prior to release.	*I am a current or prospective patient of Revelus Dermatology and authorize Revelus Dermatology to obtain my PHI from the 3rd party, physician, or facility listed below.*
DELIVERY METHOD ☐ Fax ☐ Secure e-mail ☐ Printed & pick-up ☐ Printed & mailed	REVELUS DERMATOLOGY CONTACT Fax: (512) 318-2538 Phone: (512) 815-2559 Mailing Address Revelus Dermatology 4401 West Gate Blvd, Ste 120 Austin, TX 78745

INDIVIDUAL, PHYSICIAN, OR FACILITY CONTACT INFORMATION *(This can be yourself)*

Name _____ Street _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail _____ Special Notes _____

RELEASE OR OBTAIN THE FOLLOWING *(select all that apply)*

☐ Progress Notes ☐ Pathology Reports ☐ Laboratory Reports ☐ All Records

☐ Other Records / Special Notes: _____

AUTHORIZATION & SIGNATURE

I authorize the release of my PHI as detailed above and acknowledge that certain medical information is best interpreted by a physician. I recognize that interpretations made without a physician's guidance will not render Revelus Dermatology or its healthcare professionals liable. This authorization is valid for one year from the signing date and can only be revoked in writing. My signature below confirms that I have read and understand this authorization.

_____ _____ _____

Patient, Guardian, or POA Signature Signer's Full Name Date