WESTGATE SKIN & CANCER

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Blakely Richardson, DO, FAAD
Sital Patel, DO, FAAD
Board-Certified Dermatologists

AUTHORIZATION

I understand and authorize the release of my medical records as indicated below. I understand and accept that my medical records may contain information that can only be interpreted by a physician. I understand and accept that any information interpreted by myself, and not by a physician, cannot be used to hold Health Care Professionals or the staff of Westgate Skin & Cancer liable. I understand and accept that this authorization will remain valid for one year and must be revoked in writing.

PROCESSING & HANDLING FEES (*DOES NOT APPLY IF WESTGATE SKIN & CANCER IS ACQUIRING RECORDS ON YOUR BEHALF*)

A processing and handling fee applies to all requests where medical records are released to a 3rd party. Paper records are subject to a $25 fee plus 20¢ per page after the first 20 pages. Electronic records are subject to a flat $25 fee up to 500 pages. A request must be made to determine applicable processing & handling fees. Established patients can obtain their medical records at no-cost through the patient portal.

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 Westgate Skin & Cancer. *I am submitting a request for Westgate to release medical records to the 3rd Party Physician or Facility listed below.*

☐ **To Westgate Skin & Cancer** – I am a patient at Westgate Skin & Cancer or intend to become one. *I am submitting a request for Westgate 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 Westgate Skin & Cancer. *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 _____

WESTGATE SKIN & CANCER CONTACT INFORMATION

Mailing Address
Westgate Skin & Cancer
2559 Western Trails Blvd, Ste 301
Austin TX, 78745

Medical Fax:
(512) 318-2538

Phone:
(512) 815-2559

DELIVERY METHOD (*SKIP THIS SECTION IF WESTGATE SKIN 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.

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