ADULT • PEDIATRIC
SURGICAL • COSMETIC

JULIA KAUFFMAN, M.D.
SARAH PINNEY, M.D.
BOARD CERTIFIED DERMATOLOGISTS

Authorization to Release Medical Records

Patient's Name: _____
(First) (MI) (Last)

Date of Birth: _____ Social Security #: _____

I hereby authorize the release of my photocopied medical records and request that they be transferred **FROM**:

Physician or Clinic Name: _____
Address: _____
City: _____ State _____ Zip_____
Telephone: _____ Fax: _____

I hereby authorize the release of my photocopied medical records and request that they be transferred **TO (please circle the doctor below)**:

Julia Kauffman, M.D.
915 Gessner Rd., Suite 640
Houston, TX 77024

Sarah Pinney, M.D.
915 Gessner Rd., Suite 640
Houston, TX 77024

Fax- 713-467-6980

Please transfer:

- ☐ Entire contents of chart
- ☐ Lab results
- ☐ Pathology results
- ☐ Progress notes
- ☐ Operative notes

Authorization to release medical records via fax, email, mail, or pick up: _____Yes ____No

I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I also undertand this Authorization is subject to revocation/withdrawal by me at any time in writing to the office of Julia Kauffman M.D. and Sarah Pinney M.D., except to the extent the action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in one year after signing. I have a right to inspect a copy of the health information released, and if I do not sign this Authorization, the office of Julia Kauffman M.D. Sarah Pinney M.D., will not release my medical records.

Signature of Patient/Guardian Print Name Date

Witness Signature Print Name Date