3807 Spicewood Springs Rd. Suite 201 Austin, TX 78759
Office: 512-477-3778 Fax: 512-477-3626

DEVENIR AESTHETICS MEDICAL RECORDS RELEASE

I, the undersigned, do hereby authorize (Dr.) _____
To release the information from the medical records of:

_____ _____ _____
Patient Name (please print) DOB

Records are to be: □ Given to: □ Mailed to:

_____

_____

_____

Information to be released:
□ Progress notes
□ Pathology reports
□ Laboratory reports
□ History & Physical
□ Pictures
□ Other _____

Reason for release of medical records:
□ Application for insurance claim or coverage
□ Worker's Compensation
□ Release to another physician or health professional
□ Other _____

(Article 4495b, Section 5.08 (j) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reasons or purposes for the release.")

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This authorization expires automatically ninety (90) days from the date of signature.

_____ _____
Patient or guardian signature Date

_____ _____
Relationship to patient Witness