LIMMER DERMATOLOGY
Your Skin. Our Specialty.

4630 N. Loop 1604 W., Ste. 316
San Antonio, TX 78249
Phone: 210-496-9929
Fax: 210-496-6699

Medical Record Release Form

Patient Name: _____ Date of Birth: _____

This hereby authorizes _____ to provide the use or disclosure of the personal health information as described below:

(Please check one)

☐ COMPLETE MEDICAL RECORDS	☐ OTHER _____
☐ RECORDS DATES FROM: _____TO _____	☐ SPEAK WITH PERSONS LISTED: _____
☐ MOST RECENT LABS	_____

The purpose of the disclosure: (Please check one)

☐ Request of Patient	☐ Continuing of Care
☐ Change of Doctor	☐ Insurance
☐ Referral	☐ Other _____

Please Note: *If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease you are hereby authorizing disclosure of this information.*

Release the above mentioned records to the following person(s) or entity:

☐ Dr. Byron Limmer or Dr. Rachel Limmer
4630 N. Loop 1604 W., Suite 316
San Antonio, TX 78249
Fax # 210-496-6699
Phone # 210-496-9929

☐ Name: _____
Address:_____
_____
Phone #:_____
Fax#:_____

Conditions and Notifications
This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at anytime by writing Limmer Dermatology at the address above.

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

_____ _____
Patient Signature (or patient representative) Date

_____ _____
Patient Print Name (or patient representative) Representative's Authority to Sign for Patient (i.e. parent, guardian, POA, Executer)