**Clear Lake Dermatology  
Narin (Dr. Joe) Apisarnthanarax, M.D., F.A.A.D.  
Prapand Apisarnthanarax, M.D., F.A.C.P.  
Lindsey Hunter, M.D.  
Stephanie Kokolis, PA-C  
David Raimer, M.D.**

**ALL PATIENT RECORDS AND OR RELEASES SHOULD BE EMAILED TO CLEARLAKEDERMRECORDS@GMAIL.COM**

**450 Medical Center Boulevard, Suite 309 Webster, TX 77598  
Phone: 281-332-9681 Fax: 281-332-5957**

Authorization to release healthcare information

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous name (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check one of the following options:

* I would like my records from another physician’s office sent to Clear Lake Dermatology
* I would like my records to be sent from Clear Lake Dermatology to a different physician’s office
* I would like a copy of my medical records for personal use

Provider’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This request authorization applies to (check as need be):

\_\_\_\_\_\_ Healthcare information relating to the following treatment only \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ All healthcare information

\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information is needed for:

\_\_\_\_\_\_ Continued care \_\_\_\_\_\_ Personal Use \_\_\_\_\_\_ Insurance \_\_\_\_\_\_ Legal \_\_\_\_\_Other

***EMAIL ALL PATIENT RECORDS TO CLEARLAKEDERMRECORDS@GMAIL.COM***

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but not be limited to, history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_