



Authorization for Release of Information

Name of Patient: _____ Date of Birth: ____/____/____

Center for Medical Dermatology is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Description of Information to be Released

Entity to Receive Information (Please Circle Below)

Appointment Information

Voice Mail, Spouse, Parent, Other _____

Laboratory Results

Spouse, Parent, Other _____

Financial/ Billing Information

Spouse, Parent, Other _____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the HIPAA Privacy Officer. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient or Legal Representative Date ____/____/____

Description of Legal Representative's Authority (attach necessary documentation)
