PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Regarding:
Printed Patient Name: ____ Date of Birth: _____________________

By signing this authorization, I authorize:

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to use and/or disclose certain protected health information (PHI) about me to:

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This authorization permits the following entity or person listed above to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

- ☐ Complete Medical Record
- ☐ Biopsy Report(s)
- ☐ Lab Report(s)
- ☐ Consultation Reports
- ☐ Medication Allergies
- ☐ Allergy Test/Treatment
- ☐ Surgical Procedures
- ☐ Other: ____

for dates of service from ________________________ to __________________________

Additional Comments:____

The information will be used or disclosed for the following purpose:____
If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on: ________________________ (Expiration Date, Defined Event, or 1 year if not specified)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Arizona Dermatology Group, PO Box 10730, Prescott, Arizona 86304.

____ ___________________
Patient or Legal Guardian Signature Date

☐ Mailed ☐ Hand Delivered ☐ Faxed to_________________ ☐ Other ______________ Employees Initials: _____________ Date: _________________