Associated Dermatology & Skin Cancer Clinic

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Patient Authorization for Disclosure of Health Information

Patient Name:_____ Date of Birth:_____/_____/_____
Address: _____ City: _____
State: _____ Zip: _____Phone Number: _____
I request that my protected health information (PHI) from (_____)
be disclosed to:
Recipient Name: _____
Address: _____ City: _____
State: _____ Zip:_____
Phone: _____ Fax : _____

I authorize the following PHI to be released from my medical record(s)
Covering the period of healthcare from: Specific Date(s): _____ to _____

- ○ Office Notes
- ○ Lab report
- ○ X-ray report
- ○ Pathology Report
- ○ Itemized Billing Records
- ○ Advanced Laser Clinic Records
- ○ Healthcare information relating to the following treatment or condition:_____
  _____
  _____

Purpose for requesting information:

- ○ Changing Physicians
- ○ Continuing Care
- ○ Second Opinion
- ○ Legal
- ○ Insurance
- ○ Work's Compensation
- ○ At my (patient) request
- ○ Other

Disclosure Format (Paper is default if not marked.):

- ○ US Mail – paper format
- ○ Fax (healthcare provider only)
- ○ CD – secure format
- ○ Other *(please specify)*:_____

By signing this authorization form, I understand that:

• Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Medical Records Department at the address listed above. Revocation will not apply to information that has already been disclosed in response to this authorization.

• **Unless otherwise revoked, this authorization will expire on the following date/event/condition:** _____. If I fail to specify an expiration date/event/condition, this authorization will expire *(180 days)* from the date signed.

• Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
• Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient or Authorized Representative Signature	Date
Print Name	Relationship to Patient (if applicable)