TOTAL DERMATOLOGY

Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

1. I authorize Total Dermatology to use or disclose the above named individual's health information as described below:

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ☐ Path Reports
- ☐ Medication List
- ☐ List of allergies
- ☐ Operative reports
- ☐ Most recent history and physical
- ☐ Entire Record
- ☐ Patient Account Statement/Billing Records
- ☐ Laboratory results
- ☐ X-ray and Imaging reports
- ☐ Consultation reports
- ☐ Most recent hospital reports
- ☐ Photographs

From (date): _____ to (date) _____

From (doctor's names): _____

Other: _____

3. I understand that the information in my health record may include details relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, as well as treatment for alcohol and drug abuse.

4. The information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

For the purpose: _____ ☐ At the request of the individual

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Jennifer Cork. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocationwill not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorizationwill expire on the following date, event, or condition:
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that i may inspect or copy the information to be used or disclosed, as provided in CRF 165.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carriers with it hte potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Jennifer Cork.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legale Representative, Relationship to Patient Signature of Witness

For Healthcare Organization Use Only

Date Received: _____

Patient or Patient Representative Verified by:

- ☐ Signature on File
- ☐ Driver's License
- ☐ _____

☐ Patient given copy of signed release

Staff Member Processing Request: _____