ELKHORN DERMATOLOGY

Excellence In Dermatology™ FELLOW

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Social Security Number: _____
Address: _____
Date of Birth: _____ Phone Number: _____

FACILITY TO RELEASE RECORDS:
Name: _____
Phone: _____
Fax: _____
Address: _____
City/State/Zip: _____

FACILITY TO RECEIVE RECORDS:
Name: _____
Phone: _____
Fax: _____

I hereby authorize disclosure of the following Protected Health Information:
__ Entire Medical Record __ Registration Sheet __ Complete Medical History __ Progress Notes
__ Laboratory Reports __ Billing Information __ Other _____

I understand the purpose of disclosure is for use in the following:
__ Change in Family Doctor __ Billing Company Processing __ Insurance Claim Processing __ Legal Claim Processing
__ At the Request of the Individual __ Recertification __ Other _____

I understand that by authorizing the disclosure of my "Entire Medical Record" and "Complete Medical History", I am authorizing the disclosure of Protected Health Information that includes my history of miscarriages and pregnancies, my medication history, and my inpatient/outpatient surgical history.

I understand that my protected health information includes information related to AIDS/HIV, Hepatitis, or any other blood-borne infectious disease, alcohol and substance abuse, mental health treatment, and I authorize disclosure:

_____ _____ _____
Patient Signature Print Name Date

I also understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred. The facility, it's employees, officers, and attending physicians are released from legal responsibility or liability for release of the above information to the extent indicated and authorized. I understand that the PHI that is disclosed may be re-disclosed by the authorized recipient and would no longer be protected by federal privacy regulations. I understand that I have the right to receive information regarding who has requested my PHI. **This authorization form will be in effect for 1 year** from the date of the signature; however, the patient and/or legal guardian may revoke this authorization in writing at any time by sending the revocation to the address listed below. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Additionally I understand that revocation is not valid in the event that authorization is required for insurance coverage and a claim is being contested. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

Patient/Personal Representative: _____ **Date:** _____
If Personal Representative, please provide a description of your authority to act on behalf of the patient: