ELKHORN DERMATOLOGY

**Elkhorn Dermatology**
**304 Boston Square**
**Georgetown, KY 40324**
**Phone: 502-316-9425**
**Fax: 502-316-9451**
**info@elkhorndermatology.com**

## AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Social Security Number: _____
(First) (Middle) (Last)

Address: _____ Date of Birth: _____

_____ Phone: ( ) _____

I hereby authorize _____ ( )_____ to release the following medical information to:
(Name of Facility releasing information) (Phone and/or Fax)

_____ ( )_____ Date(s) of Service: _____
(Name of Facility, agent, or individual to receive information) (Phone and/or Fax)

_____ _____
(Address) (City) (State) (Zip)

**1.** I authorize the following Protected Health Information to be disclosed:
_____ Entire Medical Record
_____ Registration Sheet (Date: _____)
_____ Complete Medical History, including Physical Exam (Date: _____)
_____ Progress Notes (Date: _____)
_____ Laboratory Reports (Date: _____)
_____ Billing Information (Date: _____)
_____ Other: _____

**2.** I understand that the purpose of this 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: _____

**3.** 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.

**4.** 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 diagnosis and treatment, and I authorize its disclosure.

_____ (Signature) _____ (Date)

**5.** 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, its employee's officers and attending physician(s) are released from legal responsibility or liability for release of the above information to the extent indicated and authorized. I understand that the Protected Health Information 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 Protected Health Information.

**This authorization form will be in effect for a period of one 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 Elkhorn Dermatology, PLLC address listed at the top of the page.

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 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:**

_____