DERMATOLOGY ASSOCIATES, LLC

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Authorization (1 year) for Use or Disclosure of Medical Information and Records

I hereby request and authorize Dermatology Associates and its employees and agents to release any and all of the information contained in my medical record and to discuss any information or medical opinions relating to the diagnosis, care, and treatment of:

Patient Name _____ Date of Birth _____ Social Security # _____

To the following agency/person:

Name _____

Address _____

Specific Description of the Information to be Used or Disclosed Including the Date of Service(s):

Information _____ Dates _____

Information that I refuse to disclose (specify): _____

If I have been diagnosed or treated for any of the following, I understand that Dermatology Associates needs my specific consent to disclose related information.

1. I (☐ **DO** ☐ **DO NOT**) authorize disclosure of information, which refers to treatment or diagnosis of drug or alcohol abuse.

2. A. I (☐ **DO** ☐ **DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of mental health
   B. I (☐ **DO** ☐ **DO NOT**) want to review this information before it is released. I understand that reviews are supervised.

3. I (☐ **DO** ☐ **DO NOT**) authorize disclosure of information which refers to HIV test results, infection status, or treatment information.

The purpose of the release: ☐ Request of Patient ☐ Other: _____

- I understand that my medical record contains information relating to my diagnosis and treatment and authorize the release of all such information listed above, except those items I have specified. I further understand that I may review my records and refuse authorization to disclose all or some of the above health care information, but that refusal may result in improper diagnosis and treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.
- I understand that if the person or entity that receives this information is not a health plan or health provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may longer be protected by federal or state law.
- This authorization is valid for a period of one year from the date of signing. I further understand that I may revoke this authorization at any time by notifying Dermatology Associates before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment enrollment in a health plan or eligibility for benefits.
- I understand that I am entitled to a copy of this authorization form.

Signature of Patient: _____ Date: _____

Print Name of Personal Representative: _____

Describe Relationship (parent, guardian, etc.): _____

Signature of Personal Representative: _____ Date: _____