AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Permission to share your health information

APDerm
Your Partner in Skin Care

A. PATIENT INFORMATION

Patient Name: _____ **Date of Birth**: _____/_____/_____(mm/dd/yyyy)

Address: _____ **Preferred Telephone**: _____ -_____-_____
(Street)

_____ _____
(City/Town) (State) (Zip)

B. PERMISSION TO SHARE: I hereby authorize **APDERM and its managed practices** including Adult & Pediatric Dermatology, PC, Advanced Dermatology & Aesthetics, Associates in Dermatology, Boston Dermatology & Laser Center, Coastal Dermatology, Dermatology Associates, Dermatology Professionals, DermCare Physicians & Surgeons, Mystic Valley Dermatology, to:

Send my protected health information to:

☐ Please send records to my address listed above.

Office/Facility Name: _____

Address: _____

_____

Telephone: _____ -_____-_____

Fax: _____ -_____-_____

Obtain my protected health information from:

Office/Facility Name: _____

Address: _____

_____

Telephone: _____ -_____-_____

Fax: _____ -_____-_____

Delivery Method: ☐ Mail ☐ Fax ☐ Other (please specify)

C. PURPOSE OF THIS REQUEST:

☐ Primary Care Physician
☐ Myself
☐ Transfer of Care Reason for transfer: ☐ Moving ☐ Dissatisfied ☐ Insurance Change ☐Other _____
☐ Disability
☐ Life Insurance
☐ Other (please specify): _____

D. INFORMATION TO BE RELEASED:

Treatment dates from _____/_____/_____ through _____/_____/_____

Type of information to share:

☐ Clinical Records (non-Cosmetic records) ☐ Surgical Procedure ☐ Lab Reports
☐ Billing Records ☐ Pathology Reports ☐ Photographs
☐ Cosmetic Services Records ☐ Other _____

E. PRIVILEGED OR SPECIFICALLY PROTECTED INFORMATION: Please check YES if you give permission to release the following information if it exists in your records:

- ☐ Yes Alcohol or Drug Abuse Treatment
- ☐ Yes HIV / AIDS diagnosis and/or treatment
- ☐ Yes Sexually Transmitted Diseases
- ☐ Yes Genetics Screening Testing results
- ☐ Yes Behavioral Health Diagnosis

F. I UNDERSTAND AND AGREE THAT:

- This authorization will expire in 12 months from the date it is signed unless a date or event is listed: _____
- I understand that this authorization pertains to information obtained on or before that date this authorization was signed.
- This authorization is voluntary, and my medical care will not be affected if I do not sign this form.
- The information that I authorize for release may be re-disclosed by the recipient and no longer protected by federal and/or state privacy regulations.
- I may revoke or cancel this authorization at any time by presenting a written request to the practice where I receive care except to the extent that my authorization has already relied upon.
- I have read this form and I had the opportunity to have my questions about this form answered in a language I understand.

Signature of Patient/Legal Representative: _____ **Date:** _____

Print Name: _____ **Legal Representative Relationship to Patient:** _____