Authorization for Disclosure of Patient Health Information (PHI)

PATIENT NAME: **DATE OF BIRTH:**

MEDICAL RECORDS GOING TO

Skin Dermatology
555 Main St, STE 1
Shrewsbury, MA 01545

Phone: (508) 644-0505
Fax: (508) 644-0506
HIPAA E-Mail: Hello@skinderm.com

MEDICALS RECORDS COMING FROM

Name: _____ Phone: _____
Address: _____ Fax: _____
City, State Zip: _____ HIPAA E-Mail: _____
Attention To: _____

INFORMATION TO BE RELEASED

☐ Entire Chart (or choose individual items below as required)
☐ Visit Note(s) ☐ Pathology Report ☐ Laboratory Report(s)
☐ Medical Care Photos ☐ Billing Statement(s)
☐ Other (please be specific): _____
Check to Exclude records pertaining to: ☐ HIV/AIDS ☐ Mental Health
☐ Genetic Testing ☐ Drug/Alcohol Diagnosis, Treatment or Referral
Date(s) of Service for the Records: _____ or ☐ All Dates

INSTRUCTIONS FOR RELEASE

Release Method: ☐ Paper ☐ Fax ☐ DVD ☐ Verbal ☐ Electronic
Due Date: As soon as possible

PURPOSE OF RELEASE

☐ Continuing Care ☐ New Provider ☐ Insurance Payment/Claim
☐ Personal Use ☐ Litigation/Legal ☐ Other _____

This authorization is valid for one-time access to the medical records and expires on _____ (date or defined event). If not specified, expires 90 (ninety) days from date signed.) I authorize release of my PHI as specified above. I do not have to sign this authorization in order to receive treatment from Skin Dermatology. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. I understand that the only way to cancel this request, except where information has already been released, is to notify Skin Dermatology in writing. I understand that the practice may receive payment or other remuneration from a third party, or charge for copying services, in exchange for disclosing PHI. I also hereby release Skin Dermatology from all legal responsibility and liability that may arise from the release of information authorized by this document.

CLIENT: _____ DATE: _____