Authorization for Release of Information

____________________________________ ______________________

Patient's Name Date of Birth

____

Street Address

____

City, State, Zip

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164). I understand that my Protected Health Information (PHI) may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulations.

I understand that my records may contain sensitive information regarding my health history. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below (for example, family members who call on my behalf asking about my diagnosis, treatment plan, etc).

I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that this authorization will not expire, but I may revoke this authorization at any time by notifying MidAmerica Skin Health & Vitality Center in writing. If I do revoke this authorization, it will not have any effect on any actions MidAmerica Skin Health & Vitality Center took before they received the revocation. I understand that I am entitled to receive a copy of this authorization and that a photocopy or facsimile copy of this authorization will be as valid as the original.

Please turn over and complete other side →

I hereby authorize MidAmerica Skin Health & Vitality Center to exchange with and/or release to the parties I have indicated below (for example, family members, spouse, physicians who call on my behalf asking about my diagnosis, treatment plan, etc):

☐ Check here and sign at the bottom if you do not wish to disclose any information.

Person(s)/Organization(s) who will be receiving/communicating the information:

Name:____

Address:____

Phone Number (_______) ____

Relation to Patient:____

Name:____

Address:____

Phone Number (_______) ____

Relation to Patient:____

Description of individually identifiable health information—please check the appropriate type(s) of information to be released or exchanged:

___________ All Treatment Plan(s)
___________ Reports/Pathology Results
___________ Clinical Records
___________ Other (Describe) ______________________________________
___________ Claim Information
___________ Laboratory Results
___________ Eligibility/Benefits

As required by the HIPAA privacy rule, I have the right to request confidential communications of my Protected Health Information or that a communication of PHI may be made by alternative means such as sending correspondence to my office or cell phone. Please check only those that apply below:

	Leave Message With Detailed Information	Leave Message With Call Back Number Only
Home Phone		
Cell Phone		
Work Phone		

____ ____________________
Signature of Patient, Parent or Legal Guardian (Required) Date