Authorizations for Use or Disclosure of PHI

I, _____, hereby authorize The Nigro
Print Name

Dermatology Group to use or disclose the following information:

(Provide description of information to be used or disclosed. Please be as specific as possible, including dates of service type (s) of document (s), etc.

As necessary for the following purpose:

(Provide purpose of disclosure. "At the request of the individual" is an adequate response)

To the following individual or party:

(Provide name, address, and other contact information for the party to whom the information is to be disclosed)

This authorization shall be in effect until: Date

(Specify date or event, e.g. "Until this authorization is revoked by the patient")

I understand that I have the right to revoke this authorization at any time and must inform The Nigro Dermatology Group of such revocation in writing. I understand that any authorization I revoke will only be effective to the extent that The Nigro Dermatology Group has not already taken action on that authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

The Nigro Dermatology Group has not and will not condition the provision of treatment, payment, enrollment or eligibility for benefits on my pro vision of this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority