AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** _____

1. Integrated Dermatology has made the Notice of Privacy Practices available to me.

2. Integrated Dermatology may access, collect, use, and disclose my health information to my primary care or referring physician, to consultants, and as necessary to others to process insurance claims, insurance applications and prescriptions.

3. Integrated Dermatology may also disclose my health information these persons:

Name: _____Phone: (_____) _____Relationship to the Patient: _____

Name: _____Phone: (_____) _____Relationship to the Patient: _____

3. Integrated Dermatology **may release my complete health record** (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse, if any), **unless indicated below**:

□ Integrated Dermatology **may not** release mental health records
□ Integrated Dermatology **may not** release record containing communicable diseases (including HIV and AIDS)
□ Integrated Dermatology **may not** release records containing alcohol/drug abuse treatment
□ Integrated Dermatology **may not** release other records (please specify):
_____

4. This authorization is effective for all of my records, including past records, and remains in effect until it is revoked in writing, unless a date is specified here: _____

5. Integrated Dermatology may provide me with information on activities and developments and may disclose my information to third parties who help Integrated Dermatology to inform me. This authorization expires 3 years after my last appointment.

6. I may revoke this authorization, in writing, at any time. This would not be effective to the extent that anyone has already relied on it, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. My treatment, payment, enrollment, or eligibility for benefits is **not** conditioned on this authorization.

8. I understand that my information may be disclosed by a third party recipient and may no longer be protected by federal or state law.

9. **SIGNATURE**

I have provided all of the required information for this form and note that it is accurate and complete. I also understand and agree to adhere to the provisions as outlined.

_____ _____/_____/_____
Patient Signature Date

OR

_____ _____/_____/_____
Responsible Party Signature Date

_____
Relationship to Patient