

Integrated Dermatology of Groton, LLC.
481 Gold Star Highway, Suite 201
Groton, CT 06340

Phone (860) 445-8020

Fax (860) 445-1665

HIPPA privacy Authorization Form. Authorization for use or disclosure of protected health information.
(Required by the Health Insurance Portability and Accountability Act 45 C.F.R. arts 160 and 164.)

Note: There is a 0.65 cent charge generally allowed under Connecticut State Law.

I authorize Integrated Dermatology of Groton (Healthcare provider) to use and disclose the protected health information described below to:

Name of Patient or Provider: _____

Town: _____ Phone: _____ Fax: _____

This Authorization of information will expire on _____

I authorize the release of my individually identifiable health information.

☐ ALL

☐ Last Office Note

☐ Labs/ Pathology Reports

Other: _____

I authorize the use or disclosure of my medical information for treatment, consultation, billing, claims, or other purposes I may direct. I understand that I may revoke this authorization in writing at any time. Revocation will not affect actions already taken or authorizations required for insurance coverage if the insurer has a legal right to contest a claim. My treatment, payment, enrollment, or eligibility for benefits does not depend on signing this form. I am aware that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal or state privacy laws.

→ _____
Signature of Patient or Personal Representative Relationship to Patient

→ _____
Printed Name of Patient Date of Birth Date

Current Address _____

Phone number _____

If moving New Address _____

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