THE DERMATOLOGY CENTER, PLLC
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P.O.BOX 1644
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Authorization to Use and Disclose Protected Health Information

PLEASE COMPLETE THE FOLLOWING INFORMATION

Patient Name: _____

SSN: _____Date of Birth: _____/_____/_____

Address: _____

Phone# _____

INFORMATION TO BE RELEASED FROM: _____

PLEASE SEND INFORMATION TO:

Name: _____ Phone# _____

Address: _____ Fax# _____

_____

PURPOSE OF DISCLOSURE: ___ Treatment or Consultation ___ at the request of the patient

____ Billing or claims payment ___ Other (Specify) _____

The Treatment dates covered by this authorization are from: _____ to _____

Please check type of information to be released:

__All records __ Laboratory/Pathology Report __ Progress Notes __ Billing Statement

__ Other _____

I understand that the information disclosed may contain testing or treatment information relating to Mental Health: Drug and/or Alcohol Abuse Treatment; Sexually Transmitted Diseases; HIV/AIDS virus.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations.

I understand that this authorization will expire in 180 days from the date signed below, unless otherwise specified. I Understand the this form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing,

I understand that refusal to sign this authorization dose not condition Treatment.

Signature of Patient or Representative **Relationship** **date**