DiPreta Dermatology

Brunswick/Camden/Jesup/Mohs Surgery & Skin Cancer Center

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To DiPreta Dermatology

(PHI Use and Disclosure)

I, _____, authorize and request the following provider/company:

Name: _____

Address: _____

Phone: _____ Fax: _____

to disclose the designated protected health information (PHI) to <u>DiPreta Dermatology</u> at the above address for the following person:

Name _____ DOB _____/_____/_____

Phone _____ Last 4 digits of Soc Security# _____

<u>Requested PHI (Check ALL that Apply):</u>

☐ All Records **Dates:** ____/____/____ to ____/____/____ ☐ Labs ☐ Pathology Reports ☐ Surgical Procedures

☐ Other: _____

<u>PURPOSE OF RELEASE</u>: ☐ Upcoming Appt ☐ Other _____

<u>DATE PREFERRED/NEEDED</u>: _____/_____/_____

This authorization is effective for 1 year from the date below, or through _____/_____/_____

Patient Rights:

I have the right to revoke this authorization at any time. I may inspect or copy the protected health information (PHI) to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I may refuse to sign this authorization and that my treatment will not be conditioned on signing. I understand released information may include a communicable disease diagnosis such as HIV.

_____ _____ _____/_____/_____

Signature of Patient (18 older) or Guardian **Relationship** **Date**

2020 HIPAA Privacy (DDerm Staff Only) ***Form updated: Jan 2021***

Office Location: _____ Reviewed by: _____ Handled/Sent by: _____ on ____/____/____

Acct#___«Person_ID»___ Patient: __«Person_First_Middle_Last»____ DOB: _«Person_Birth_Date»__