U.S. DERMATOLOGY partners

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name:		Patient Date of Birth:	
Patient Street Address:			
Patient City, State, Zip:		Patient Phone Number:	( )

The following individual or organization is authorized to make the disclosure:
☐ U.S. Dermatology Partners may disclose protected health information of the above named patient *to* the individual or organization listed below.
☐ The individual or organization listed below may disclose protected health information *to* U.S. Dermatology Partners.

Name of individual or organization:					
Address of individual or organization:					
Phone Number:	( )		Fax Number	( )	
Records may be:	☐ Mailed to above address	☐ Faxed to above #	☐ Electronic (only available in patient portal)		
Purpose of Use/Disclosure:	☐ Patient Access	☐ To Doctor	☐ To Insurance	☐ To Attorney	☐ Other _____
Treatment Dates of protected health information to be disclosed:			From:	To:	
Information to be Disclosed:	☐ Medical Records		☐ Billing Records	☐ Pathology Report ONLY	
This is a:	☐ One-Time Disclosure		☐ Continuing Disclosure for 12 months		

I understand as the patient or person authorized to act on the patient's behalf the following applies:

- I am entitled to receive a copy of this authorization, and the requester may be provided a copy of this authorization.
- I am entitled to inspect my records and that a reasonable fee may be charged for the records.
- I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality.
- I release U.S. Dermatology Partners from any legal responsibility or liability for disclosure that may arise as a result of the use of the information contained in the Protected Health Information.
- I understand that the information in my record may include information relating to sexually transmitted diseases, IDS, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment.

Patient Printed Name:	
Patient DOB:	
Parent/Legal Guardian Printed Name:	
Relationship to Patient:	
Signature:	
Date:	