PREMIER DERMATOLOGY

MEDICAL • SURGICAL • COSMETIC

Patient name: _____ **Date of birth:** _____

Any former/alternative names patient has used: _____

I. <u>Patient's Authorization:</u> You may use or disclose the following health care information:

☐ All my health information maintained by the above named practice

☐ My health information relating to the following treatment or condition:

☐ My health information for the date(s):

☐ Other: _____

You may disclose this health information to:

_____

_____

(Name, phone, fax, address)

You may disclose this health information from:

_____

_____

(Name, phone, fax, address)

Reason(s) for this authorization (check all that apply):

_____

This authorization ends: _____ *(One year from the date signed unless specified for an earlier time)*

II. <u>Patient's Rights</u>

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

However, I do have to sign an authorization form:

- To take part in a research study OR
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Please write a letter to the office if you wish to revoke this authorization. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Signature: _____ **Date:** _____ **Time:** _____

Signature of authorized individual & relationship to patient : _____

Date: _____ **Time:** _____