Patient Release of Protected health Information Authorization

Patient Name: ____ **Date:** ____________________

Date of Birth: ____________________________

I authorize ____
Name

____
Address City State Zip

________________________________ ________________________________
Phone Number Fax Number

To disclose or release protected health information about me/ patient to:

Anders Dermatology, Incorporated
4126 N. Holland Sylvania Rd., Suite 200
Toledo, Oh 43623
Phone: 419-473-3257 Fax: 419-473-8816

I am authorizing disclosure of the following protected health information about me to the recipient above:

______Office notes, lab (blood, urine and biopsy), and x-ray only from the last year or from the last____years.

______ Entire patient record **or** check **only** those items of the record to be disclosed:

______ Office Notes ______ All Biopsy Results _____Other Lab Results ______ X-ray Results

______ Record of HIV & communicable Disease testing

______ Record of Mental Health or Substance Abuse Treatment

______ other (please specify):_______________________________________

Purpose of Disclosure:

______ Continuity of Care ______ Patient request ______ Patient transferring care

Expiration / termination of authorization: This authorization will expire one year from date signed . You must submit a new authorization after the expiration date to continue the authorization.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting in writing to our Privacy Manager. Such request will not affect actions taken by us prior to the date we received the written revocation.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Signature:____ Date:_____________________
Patient / patient authorized representative

02/2012