Patient Release of Protected health Information Authorization

Patient Name: _____ **Date:** _____

Date of Birth: _____

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

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

_____
Name

_____
Address City State Zip

_____ _____
Phone Number Fax Number

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.

Redisclosure: Once authorized protected health information is released, it maybe subject to re-disclosure by the recipient and may no longer be protected by the requirements of the Privacy Practice Rules.

Signature:_____ Date:_____
Patient / patient authorized representative