MODERN DERMATOLOGY

WESTPORT, CT

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AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION (PHI)

patient's last name ______ first name ______ middle ______ date of birth ______ former name, *if any* ______

social security number ______ phone number ______

1. By signing this authorization, I authorize Modern Dermatology to use and/or disclose certain protected health information (PHI) about me to:

____
name address

2. This authorization permits Modern Dermatology to use and disclose the following identifiable health information about me (specifically describe PHI to be used or disclosed, such as dates of service, type of services, level of detail to be released, origin of information etc.) ______________________________

____

3. Information to be released via: ☐ mail to: ______ ☐ pick up ☐ fax # ______

☐ entire medical record ☐ HIV (AIDS) related ☐ diagnostic test results ☐ photographs

☐ only those portions pertaining to: ______________________________

4. This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed. ☐ I DO NOT consent.

5. This information will be used or disclosed for the following purposes:

☐ further medical care ☐ payment of insurance claim ☐ legal investigation

☐ applying for insurance ☐ disability determination ☐ at the request of the individual

☐ other – specify: ______________________________

6. This authorization is valid for one time access to the medical records, and expires on (please complete) ______ (date or defined event. If not specified, expires 90 (ninety) days from date signed.)

I authorize release of my PHI as specified above. I do not have to sign this authorization in order to receive treatment from Modern Dermatology. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy ruIe. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. I understand that the only way to cancel this request, except where information has already been released, is to notify Modern Dermatology Medical Records Department in writing. I understand that the practice may receive payment or other remuneration from a third party, or charge for copying services, in exchange for disclosing PHI. I also hereby release Modern Dermatology from all legal responsibility and liability that mayarise from the release of information authorized by this document.

7. Signature of patient: ______________________________ date: ______

If signed by anyone other than the patient, state relationship and/or reason and legal authority to do so:

Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased

Legal authority: ☐ legal guardian ☐ next of kin of deceased

8. Signature of witness: ______ Written name of witness: ______ date: ______

Medical Records Department Use

date received ______ processed by ______ date released ______

☐ sent by mail ☐ pick up in person ☐ faxed (confirmation sheet attached is possible)