ASSOCIATED DERMATOLOGISTS

AUTHORIZATION TO DISCLOSURE PROTECTED HEALTH INFORMATION

Authorization may be invalid if form not completely filled out

Patient Information:			
Patient Name			DOB
Address			Phone Number
City		State	Zip Code
Release Records Form:			
Provider/Organization			
Address		City	
State	Zip Code	Phone Number	Fax Number
Release Records To:			
Provider/Organization			
Address		City	
State	Zip Code	Phone Number	Fax Number

Purpose for disclosure:

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

Treatment Date(s):

☐ Treatment dates from _____ to _____ ☐ Specific date: _____ ☐ ALL treatment dates

Information to be released:

☐ Complete Health Record	☐ History & Physical	☐ Consultations	☐ Other *(please specify)*
☐ Clinic Notes	☐ Laboratory Reports	☐ Immunization Records	
☐ Hospital Notes	☐ Pathology Reports	☐ Patient Billing Records	
☐ Discharge Summary	☐ Radiology Reports	☐ Photographs	

I, the undersigned, request and authorize release of health information as indicated/described above. I understand that:

- The requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. This authorization does not include permission to release outpatient Psychotherapy Notes. Release of Psychotherapy Notes requires a separate authorization.
- This authorization will expire one-year from the date signed below unless specified (_____) or revoked in writing by myself (or authorized representative). Any revocation will not apply to information that has already been released in response to this authorization.
- I may refuse to sign this authorization. Refusal will not affect my treatment, payment, enrollment, or eligibility for benefits.
- After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

Signature of Patient (or Authorized Representative)	
Printed Name	*Date*
If Authorized Representative, please explain authority to act on the behalf of the Patient and documentary evidence of appropriate papers shall be required to accompany this authorization	

6330 Orchard Lake Road, Suite 120 · **West Bloomfield**, MI 48322 · *Phone:* 248.855.3366 · *Fax:* 248.855.6213
9640 Commerce Road, Suite 100 · **Commerce**, MI 48382 · *Phone:* 248.694.6390 · *Fax:* 248.694.6391
46325 West Twelve Mile Road, Suite 370 · **Novi**, MI 48377 · *Phone:* 248.773.3640 · *Fax:* 248.773.3647
27901 Woodward Avenue, Suite 200 · **Berkley**, MI 48072 · *Phone:* 248.307.8200 · *Fax:* 248.307.8201
31275 Northwestern Highway, Suite 140 · **Farmington Hills**, MI 48334 · *Phone:* 248.538.0219 · *Fax:* 248.855.6213