DERMATOLOGISTS
OF CENTRAL STATES

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# Authorization to Disclose 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 From:** | | | |
| **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*** | |

 Last Updated: 10/28/2019