PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ____ DOB: ________________ SSN: ______________________

1. I authorize Village Dermatology to use or release/disclose my health information as described below.

2. The type and amount of information to be used or disclosed is as follows: (includes dates where appropriate)

- ☐ Problem List
- ☐ Medication List
- ☐ List of Allergies
- ☐ Laboratory results
- ☐ Pathology results
- ☐ Patient Account Statement/Billing Records
- ☐ Medical visits/notes
- ☐ Cosmetic visit/notes
- ☐ Entire record
- ☐ From (date) ___________________ to (date) __________________

3. The identified information may be used by or released to the following individual(s) or organization(s):

NAME: ____
ADDRESS: ____
PHONE: ____
FAX: ____

This authorization will expire on (insert date or event): ____
*If I fail to specify an expiration date, this form will expire twelve (12) months from the date on which it was signed.

4. I understand my health record may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol/drug abuse.
5. I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
6. I understand I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to Village Dermatology. The revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

____ ______________________
Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other: ____________________________

____ ______________________
Witness Signature Date

VILLAGE DERMATOLOGY

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