DERMATOLOGY™
ASSOCIATES, P.A.

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

With my signature below, I authorize the listed physician/provider and their designated staff members to disclose certain protected health information (PHI) about me.

This authorization permits: _____

_____

_____

to disclose to: Dermatology Associates, P.A.
317 Tanner Road
Greenville, SC29607
Tel: (864) 627-8911 FAX: (864) 627-8294

the following information:

___ Complete Medical Record

___ *Only the Following:*

___ Biopsy Reports
___ Lab Reports
___ Medication Allergies
___ Surgical Procedures
___ Office Notes
___ Consultation Reports
___ Allergy Tests/Treatment
___ Other _____

This protected health information is being used or disclosed for the following purposes:

_____

*or*___ at the request of the individual.

This authorization will expire on _____.

My physician will not condition my treatment, payment or enrollment in health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

When my information is disclosed to Dermatology Associates, P.A., pursuant to this authorization, Dermatology Associates, P.A. will observe privacy protection as determined by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except to the extent that Dermatology Associates, P.A. has acted in reliance upon this authorization. My written revocation must be submitted to the releasing physician/provider listed above.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____
Printed Name of Patient or Legal Guardian

_____ _____
Patient's Date of Birth Patient's Social Security Number

_____
Date