DERMATOLOGY ASSOCIATES, P.A.

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

By signing this authorization, I authorize Dermatology Associates, P.A. and its designated staff members to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Dermatology Associates, P.A. to use or disclose to:

_____

_____

_____

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 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 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 Dermatology Associates, P.A., 28 Medical Ridge Drive, Greenville, SC 29605.

_____
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

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