THE CENTER FOR DERMATOLOGY CARE

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization,

_____ _____ _____

Patient's name Social Security # Date of Birth

authorizes _____ to use and/or disclose certain protected health information (PHI) about me to:

_____ _____

Name to Release to Address

_____

Phone/fax

I authorize the disclosure or the following individually identifiable health information about me.
(Date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____.

The information will be used or disclosed for the following purpose:

_____.

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____
{Expiration Date or Defined Event}.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from The Center for Dermatology Care. In fact, I have the right to refuse to sign this authorization. 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 the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at The Center for Dermatology Care, 267 W. Hillcrest Dr., Thousand Oaks, CA, 91360.

Signed by:_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian