Renew
FAMILY DERMATOLOGY

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Patient Authorization for Practice to Release/Obtain Medical Information

Name of Patient:_____ **DOB:** _____

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA)

Authorization:

I authorize_____(health care Provider)_____(phone/fax number) to use and disclose the protected health information described below to Renew Family Dermatology and its personnel.

Type of information to be used or disclosed: (check or circle all that apply)

- o Medication List with list of allergies
- o Laboratory results
- o Pathology results
- o Medical Visits/notes
- o Entire record
- o Patient account statement/billing records
- o Other_____

Expiration date of this authorization: 30 days unless otherwise stated by patient in writing.

I understand my health record may include information relating to sexually transmitted disease(s), HIV, or AIDS. It may also include information about behavioral or mental health services and/or treatment for alcohol/drug abuse.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or I my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Submit your revocation to the Privacy Officer of Renew Family Dermatology LLC.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient signature (or signature of person completing form **Date**

Relationship to patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other :_____

_____ _____

Witness Signature **Date**