HMGS DERMATOLOGY

HMGS Business office
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HIPAA AUTHORIZATION TO RELEASE AND DISCLOSURE PATIENT INFORMATION

PATIENT INFORMATION:	**Name:**	**Date of Birth:**
	Address:	**Phone:**
	City/State	**Zip**
HEALTH CARE PROVIDER: *Who has the information you want to be released?*	**Name:**	**Phone:**
	Address:	**Fax:**
	City/State	**Zip**
RECEIVING PARTY: *Where do you want the information sent?*	**Name:**	**Phone:**
	Address:	**Fax:**
	City/State	**Zip**
INFORMATION TO BE RELEASED *What do you want sent or released? Check all applicable boxes*	☐ **Complete Health Record** ☐ **Biopsy Reports** ☐ **Lab Testing Results** ☐ **Other:** *Please specify:* _____ _____ ☐ **For the following date range: From _____ To _____** *or* ☐ **For all Dates of Service**	
PURPOSE OF RELEASE *Why is it needed?*	☐ **Continuing care** ☐ **Second Opinion** ☐ **Research** ☐ **Disability** ☐ **Legal** ☐ **Insurance** ☐ **School** ☐ **Other: _____**	

- This authorization lasts for one year after the date you sign it unless you enter a different date here _____
- This authorization may be canceled in writing at any time, by providing written notice to the releasing provider, and attention to the privacy officer. A cancellation will not change releases that happen before the cancellation.
- The releasing provider will not restrict your treatment if you choose not to sign this authorization.
- A photocopy or other electronic copy of this authorization will be treated as an original.
- The releasing provider may have received health records from other providers which have been incorporated into your records at the releasing provider. If those records are included in those authorized above, they will be released.
- The releasing provider cannot prevent the re-disclosure of your information by the person or organization that received your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release the releasing provider from any and all liability resulting from disclosure by the recipient.
- Your signature below indicates you have read and understand this form, authorize the release of your information as described above, and have received a copy of this authorization form.

Signed by: _____ **Date:** _____

Signature of Individual or Legal Guardian/Representative

_____ _____

Print Name of Individual or Legal Guardian/Representative

Relationship to Individual/Legal Authority