PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _________________________ Medical Record#: _________________________
Date of Birth: _________ Soc. Sec. #: ________________ Phone#: _______________________
I hereby authorize PERIMETER DERMATOLOGY to release the following information contained in my medical records for the period from: _________________________ to _________________________.

☐ All PHI including confidential ☐ All PHI except confidential selected below *

*(*Note: While specific Confidential PHI will not be included, the information authorized for release may make reference to confidential findings.)*

Confidential: ☐ HIV Test Results ☐ Alcohol & Drug Therapy ☐ Mental Health Treatment Records
☐ Clinic Notes for Doctors ☐ Lab Reports ☐ X-ray reports
☐ Other (please specify): ____

Release of PHI is for: ☐ Attorney ☐ Doctor ☐ Insurance
☐ Other (please specify) ______________________________________

Mail to (Name & Address):

____

____

____

This is: ☐ A One-time Disclosure ☐ A Continuing Disclosure for 12 Months

I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality.

Unless I otherwise revoke this authorization in writing it shall expire on the following date, event, or condition: ____. At that time no express revocation shall be needed to terminate my authorization. I hereby release **PERIMETER DERMATOLOGY, PC** from any legal responsibility or liability for disclosures that may arise as a result of the use of the information contained in the PHI released.

___________________________________ ___________________________________
Signature Relationship to Patient (if applicable)

___________________________________ ___________________________________
Signature of Witness (if needed) Date

The employee receiving this revocation must fill out the following information and then place the signed original in the designated place in patient's chart under the Authorizations tab.

___________________________________ ___________________________________
Signature of employee receiving revocation Date received