

AUTHORIZATION & RELEASE OF PROTECTED HEALTH INFORMATION

Dermatology Associates requires all patients to complete this form to indicate patient authorization to use and/or disclose certain protected health information (PHI) to the party or parties listed below in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law.

I authorize all Dermatology Associates of Morris, P.A. staff to use or disclose all protected health information, unless I note restrictions, to the individual(s) listed below until the specified expiration date. I have the right to revoke this authorization which must be in writing.

The listed individual(s) may receive all protected health information, unless written restrictions are provided:

Print Name _____

Phone Number Relationship Date Authorization will expire or indefinite

Print Name _____

Phone Number Relationship Date Authorization will expire or indefinite

Print Name _____

Phone Number Relationship Date Authorization will expire or indefinite

By signing this form, you authorize the Practice to disclose Protected Health Information to the individuals listed. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any previous disclosures we have already made in reliance on your prior authorization.

Print Patient Name

Signature (Patient or Parent/Legal Guardian)

Date