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Authorization for Use/Release of Health Information

(This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purposes.)

By signing this form, I authorize Dermatology Associates of Atlanta, P.C. to use, release or disclose the protected health information described below to:

Name and Address of person(s), Organization, to Whom Information Should be sent

Please send this information on or about (information will not be resent without another authorization):

____ / ____ / ____

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.). Please allow at least 7-10 business days for coping and mailing.

___ Copies of all medical records for the period ____ / ____ / ____ to ____ / ____ / ____

___ Copies of information described below for the period ____ / ____ / ____ to ____ / ____ / ____

___ History & Physician Examination ___ Lab Reports ___ Reports from other Physicians

___ Other (Please Specify) _____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted disease; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released, even if occurring during dates above

I understand that Dermatology Associates of Atlanta, P.C. assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Dermatology Associates of Atlanta, P.C. from all legal liability that may arise from this authorization.

Print Name: _____

Patient's Signature: _____ Date: _____

SS# _____ - _____ - _____ DOB ____ / ____ / ____

If the signature above is not that of the patient, I am acting for the patient because _____

My relationship to the **patient** is: _____

The patient, or their representative, may revoke this authorization by notifying, in writing, Dermatology Associates of Atlanta, P.C. designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization, if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information release under this authorization may be subject to redisclosure by the recipient.

Revised 7/10