english DERMATOLOGY
HEALTHY SKIN IS OUR PASSION

Authorization for Use or Disclosure of Medical Record Information

Medical Record #

Patient Information

Patient Full Name:______________________ Date of Birth:____________
Patient Address:______________________ Home Phone:____________
City:____________ State:______ Zip:________ Work Phone:____________

Release Information To

I authorize West Dermatology to release my medical records to the following:

☐ Mail Copies To *(address below)* ☐ Hold for Patient Pick-up *(address below)*

Name/Facility:______________________ Attention:____________
Address:______________________
City:____________ State:______ Zip:________ Phone:____________

Purpose of Request: ○ *Personal ○ Continuing Care ○ *Other____________

Information to be Released

PLEASE BE SPECIFIC - include dates of treatment & provider name if applicable.

______________________ Date(s) of Treatment:____________
______________________ Date(s) of Treatment:____________
______________________ Date(s) of Treatment:____________

○ I have been granted Power of Attorney or Guardianship of the patient as indicated by the attached document.

Authorization for Release of Statutorily Protected Information

DO NOT Leave This Section Blank - The requested medical record MAY or MAY NOT contain information that is statutorily protected. You must check either "Yes" or "No" and initial each category for West Dermatology to properly process your medical record request.

	Release Records? Check one		
	Yes or	**No**	
Mental Health	☐	☐	Initial Here:________
HIV Tests & Related Information	☐	☐	Initial Here:________
Alcohol and/or Substance Abuse	☐	☐	Initial Here:________

Please confirm that you have checked "Yes" or "No" and initialed all 3 protected information categories above even if they do not necessarily apply to the patient's records. If information is not released and/or form is incomplete, West Dermatology may be unable to fulfill this request.

Sensitive Information

Please check or indicate below any sensitive information that you **DO NOT** want released.

☐ Abortion ☐ Sexually Transmitted Disease ☐ AIDS/ARC
☐ Genetic ☐ Domestic Sexual Assault ☐ Other(s)____________

This authorization is effective for one year from the date of signing unless a different date is specified here:____________.
This authorization maybe revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.
A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.
NOTICE: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

____
Patient's Signature/Date

Know Your Privacy Rights

refer to the HIPAA
"PRIVACY NOTICE"

____
Parent/Legally Recognized Representative Signature/Relationship to Patient**/Date

____
Witness/Date

**By my signature, I attest that I am the legally recognized representative of the above-mentioned patient in accordance with the following ____________. The information release pursuant to this Authorization may be disclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. West Dermatology will not condition treatment or payment of the provision of this Authorization. Patient does have a right to receive a copy of this form.

PLEASE FAX BACK TO (702) 835-1032