Authorization for Release of Protected Health Information (PHI)

Today's Date: __/__/_____

Patient Name: _____

Date of Birth __/__/_____

Street Address: _____

Apt #: _____

City: _____ State: _____ Zip: _____

Phone #: _____

The undersigned hereby authorizes the facility/provider named below to disclose my health information:

Name (facility releasing information):

_____

Address:

_____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Provider: _____

Date(s) of Service Requested (if known): _____

Description of Information to be released: *(check all that apply)*

☐ Progress Notes

☐ Consultations

☐ Most Recent History & Physical

☐ Immunization Record

☐ Laboratory Reports

☐ Radiology/Imaging Reports

☐ Radiology Films

☐ Two-way Verbal Exchange of Communication

☐ Entire Medical Record

☐ Other _____

I understand that the information in my health record may include information relating to communicable diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization (receiving the information).

Name (facility releasing information):_____

Address:_____

City:_____ State: _____ Zip: _____

Phone #: _____ Fax #:_____

ATLANTA DERMATOLOGY & LASER SURGERY

Description of the purpose of the use and/or disclosure: *(check one)*

☐ Continuing Care

☐ Collaborating of Care

☐ Confidential Legal Purposes

☐ Second Opinion

☐ Emergency/Acute Care

☐ Personal Use

☐ Social Security/Disability

☐ Insurance

☐ Other _____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. Atlanta Dermatology & Laser Surgery may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify.

This authorization will be in effect until _____ (day or event).

I further understand that I may revoke this authorization at any time by notifying Atlanta Dermatology & Laser Surgery. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect my actions taken before the receipt of the written revocation.

The above information is accurate and complete to the best of my knowledge.

_____ Date Signed

_____ Signature of Patient or Patient's Representative

Name:_____
(Please print)