renew dermatology #

1603 Santa Rosa Road, Suite 203
Richmond, VA 23229
P: 804.440.3376
F: 804.440.3377

Authorization to Disclose Protected Health Information

Date: _____

Patient's Name (please print): _____

Patient's Address: _____
Street City State Zip Code

Patient's Date of Birth: _____ **Patient's SS#/Chart#:** _____

Release Information FROM:

Organization Name: _____

Provider Name: _____

Address: _____

_____

Release Information TO:

Organization Name: _____

Provider Name: _____

Address: _____

_____

Covering the period of healthcare: **From** (date) _____/_____/_____ **To** (date) _____/_____/_____

Information authorized for disclosure:

- ☐ Complete Health Record ☐ Laboratory Tests ☐ Pathology Reports
- ☐ Other (please specify) _____

The purpose for which disclosure is authorized (check all that apply)

- ☐ Medical Care ☐ Insurance ☐ Benefit Eligibility ☐ Other _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and provide my written revocation to the provider of care. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to review or contest a claim. Unless otherwise revoked, this authorization will expire _____/_____/_____. If a date is not specified, this authorization will expire in 90 days.

I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____/_____/_____
Signed: Patient – (parent or legal representative) **Date**

Witness Signature: _____

Office Use Only:

- ☐ Identity checked

Name/Title of Person Releasing Information: _____ Date _____/_____/_____