Patient Authorization for Practice to Release Protected Health Information

ENGLERT DERMATOLOGY/NORTH BALTIMORE DERMATOLOGY/ADVANCED DERMATOLOGY BEL AIR

Patient's Full Name _____ Birth Date (MM/DD/YY) _____

Street Address _____ City/State/Zip Code _____

Phone Number _____

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. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Specific description of the information to be used or disclosed, including the specific purpose:

_____Pathology Reports ____Laboratory Reports ____Progress Notes ____Operative Notes

_____ Other (Please List)_____

Purpose of Disclosure:

_____Referral to Specialist ____Legal Investigation ____Worker's Compensation ____Insurance ____Personal

____Disability Determination ____Other (Please List)_____

Individuals who may use or disclose this information:

_____Englert Dermatology / North Baltimore Dermatology / Advanced Dermatology Bel Air

_____Other (Please List)_____

Individuals who may receive and use the disclosed information: (include address)

Name (Physician, Hospital, Agency, etc.) _____

Street Address _____ City/State/Zip Code _____

Phone Number _____ Fax Number _____

Expiration date of this authorization:_____

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to the Practice.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

I, as the patient understand that I am responsible for the preparation fee of $15 (if the practice sends the records to another provider or entity) and a copying charge of $.50 per page. Please note that the processing of medical records can take up to two (2) weeks.

Signature: _____ Date:_____

This authorization was signed by:_ _____

Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____