AFFILIATED DERMATOLOGY & COSMETIC SURGERY CENTER, INC.
650 Shawan Falls Drive • Dublin, OH 43017 • Phone: 614-764-1711 • Fax: 614-889-2652

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HIPAA Laws prevent us from discussing your protected health information with family or friends unless you designate the individual(s) with whom we may release information. Please complete this form to designate the individual(s) to whom we may release your protected health information. If you do not wish to designate anyone, please √ the appropriate box below.

Date: ________________

Patient's Name (please print): ______________________________ Date of Birth: __________

Address: ______________________________ Phone Number: __________

Street/City/State/Zip Code

I authorize Affiliated Dermatology & Cosmetic Surgery Center to discuss my protected health information with the individuals listed below:

1) Name: ____________ DOB: ______ Relationship to patient: ____________ Ph #: __________

2) Name: ____________ DOB: ______ Relationship to patient: ____________ Ph #: __________

3) Name: ____________ DOB: ______ Relationship to patient: ____________ Ph #: __________

☐ Please only discuss my protected health information with me

Protected health information includes the following. **Please choose "NO" in each box following the medical information not to be discussed, and choose"YES" in each box following the medical information that may be discussed.**
Please initial on the line next to each item.

Item	YES/NO	Initial	Item	YES/NO	Initial
History and Physical		______	Pathology Report		______
Lab Tests*		______	Photographs/videotapes/ digital/other images		______
Progress Notes		______	Other __________		______
Operative Report		______			

*Lab tests do NOT include results for HIV antibodies unless listed below.
I authorize use or disclosure of (check box and initial below):

☐ ________ Lab test results for HIV antibodies

The purpose of the authorized use or disclosure of the information above is as follows:

☐ At the request of the patient

☐ Other ____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and may no longer be protected by federal or state law.

I understand that I may revoke the authorization in writing at any time, except to the extent that action has been taken by Affiliated Dermatology in reliance on this authorization, by sending a written revocation to M. Morgan or L. Johannsen at the above address.

I understand that I have the right to:

- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

This authorization will expire ______________________________ OR ☐ Ongoing

Insert Applicable Date or Specific Event — Checking this box means form will NOT expire

____
Signature of Patient or Patient's Personal Representative

____
Date

____
Printed Name of Personal Representative, if applicable

____
Relationship of Personal Representative to patient

____
Signature of Affiliated Dermatology Representative

____
Date