my dermatologist
TRUSTED SKIN CARE

Authorization to share Protected Health Information (PHI)

I, (patient, parent, legal guardian), _____ (print name), hereby authorize My Dermatologist to share PHI verbally or in writing with:

Name_____

Relationship_____ Phone Number_____

Regarding:

Patient Name_____ Date of Birth _____

My Dermatologist will share any protected health information other than what is indicated below unless initialed to do so.

State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information shared. If not indicated, information will not be shared, released, or obtained.

_____Alcohol, Drug, Substance Abuse Records
_____Psychiatric Evaluation/Treatment
_____HIV/AIDS Testing/Treatment
_____Genetic Records

Unless otherwise revoked, this authorization will expire on the following event: Termination or Discharge from clinic.

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to My Dermatologist
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Patient/Guardian Signature Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)