Susan Oldenkamp, M.D.
Dermatology

Fax (855)847-9924

AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION:

I, the undersigned, request a copy of my medical records be released from: **SusanOldenkamp,M.D**

These copies will be released
to:____

____

YOU MAY USE OR DISCLOSE THE FOLLOWING (please check all that apply):
___All health care information in my medical record.
___Health care information in my medical record relating to the following treatment/ condition/
dates:____

____

__Other (please specify)____

YOU MAY USE OR DISCLOSE INFORMATION REGARDING TESTING, DIAGNOSIS AND TREATMENT FOR (check all that apply):
___HIV (AIDS virus)
___Mental health / psychiatric conditions
___Sexually transmitted diseases
___Drug and or alcohol abuse

I SPECIFICALLY EXCLUDE THE FOLLOWING FROM BEING USED OR DISCLOSED:
Please specify:____

AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE SIGNED.

PATIENT RIGHTS:
My signature below indicates that I understand that:
I do not have to sign this authorization in order to receive health care benefits (treatment, payment, or enrollment).
I have to sign this authorization form:
To take part in a research study:
To receive health care when the purpose is to create health information for a third party (sports physical, employer etc.)

There is the potential that my information will no longer be protected by the HIPPA privacy rule when released and that my information may be re-disclosed by the recipient.

I may revoke this authorization in writing at any time. If I do so, this will not affect any actions already taken by Susan Oldenkamp, M.D. in accordance with the authorization.

Name of Patient: ________________________________DOB:__________ SSN:_____________

Name of legal representative:_________________________ Relationship to patient_____________

Signature of patient / represenative:____________________Date:_______________