SKIN SPECIALISTS
OF THE CAPITAL REGION
SKINSPECIALISTSCR.COM

Authorization to Disclose Protected Health Information

RELEASE INFORMATION FROM:
Specify Provider Name and Address:
Provider Name: _____
Address: _____
_____
_____

RELEASE INFORMATION TO:
Specify Provider Name and Address:
Provider Name: _____
Address: _____
_____
_____

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information. My identifying information is as follows:

Patient's Full Name: _____
Maiden or Other Name: _____
Date of Birth: _____
Address: _____

Time period of records to be released: All Dates _____ OR
From (Date) ____/____/____ To: (Date) ____/____/____

Information authorized for disclosure:

- ☐ Complete Health Record
- ☐ Specific Office Visit Record - Date: _____
- ☐ Pathology Reports
- ☐ Laboratory Reports
- ☐ Other (Please Specify) _____

If applicable, I also give permission for the following "Sensitive Protected Health Information" to be disclosed.

- ☐ Acquired Immunodeficiency SYndrome (AIDS) or Human Immunodeficiency Virus Status (HIV)
- ☐ Behavioral Health Services/Psychiatric Care
- ☐ Treatment for Alcohol and/or Drug Abuse
- ☐ Genetic Counseling/Testing

____(Initial) I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the privacy regulation or statutes and laws and that any disclosure of healthcare information carries with it the potential for unauthorized future redisclosures.

Unless otherwise specified, this authorization is valid only for 90 days and will expire 90 days after my signature. I understand that I may revoke this authorization at any time by notifying the authorized party in writing.

This facility, its employees, officers and physicians are hereby released from any liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____ _____
Signed: Patient, Legal Representative, Parent or Guardian (Relationship if not Patient Date