AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION HIPAA

I. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____ Date of Birth: _____,

II. AUTHORIZATION. I authorize Augusta Dermatology & Aesthetics to use or disclose the following: (check one)

☐ - All of my medical-related information.

☐ - My medical information ONLY related to: _____.

☐ - My medical-related information from _____ to _____,

☐ - Other: _____. Hereinafter known as the "Medical Records."

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ - Any party that is approved by the Authorized Party.

☐ - ONLY the following party:

Name: _____

Address: _____

Phone: (____) ____-_____ Fax: (____) ____-_____ E-Mail: _____

IV. PURPOSE. The reason for this authorization is: (check one)

☐ - General Purpose. At my request (general).

☐ - To Receive Payment. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.

☐ - Other: _____.

V. TERMINATION. This authorization will terminate: (check one)

☐ - Upon sending a written revocation to the Authorization Party.

☐ - On the following date: _____

☐ - Other: _____.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ - Being a Minor. Patient is ____ years old and considered a minor under state law.

☐ - Being Incapacitated. Patient is incapacitated due to: _____.

☐ - Other: _____.

Signature of Representative: _____ Date: _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____.

I. ADDITIONAL CONSENT FOR CERTAIN CONDITIONS I. SENSITIVE INFORMATION.

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released. (check one) ☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

II. HIV/AIDS.

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released. (check one)

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____