ASSOCIATES IN DERMATOLOGY
Your Skin Cancer and Skincare Specialists

PATIENT AUTHORIZATION FOR ASSOCIATES IN DERMATOLOGY TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

Processing of Medical Records normally takes 1-2 weeks, but can take up to 30 days

_____
Pt. Initials

By signing this authorization, I authorize ASSOCIATES in DERMATOLOGY to release certain protected health information (PHI) about me to:

Name:_____

Address:_____

FAX:_____

Please send copies of the following:
☐ **Office Notes (From date/to)_____** ☐ **Operative Report (From date/to)_____**

☐ **Pathology Report (From date/to)_____** ☐ **Lab Report (From date/to)_____**

This information will be used or disclosed for the following purpose:
☐ **Change of Physician** ☐**Relocation** ☐**Insurance** ☐**Legal Matter** ☐**Personal Copy**

☐ **Cancer Policy** ☐ **Disability** ☐ **Other:_____**

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS, if any, with the rest of my medical records.
Initial_____ Date: _____Dates of treatment: _____

The purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on provision of the PHI specified above. I do not have to sign the authorization to receive treatment from Associates in Dermatology. In fact, I have the right not to sign; however, if I do not sign the information will not be released. If the information is released to a party other than a health care provider, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal
HIPAA Privacy Rule.

I give my approval to have this information transmitted by mail, fax, or electronic means. I have the right to revoke this authorization in writing except to the extent that the parties have acted in reliance upon this authorization. **This authorization expires automatically ninety (90) days from the date of signature, unless the physician prior to that date receives revocation.**

My revocation must be submitted in writing to:
Privacy Officer
PO Box 690609
Orlando, FL 32869

I agree to pay $1.00 per page for the first 25 pages of written material and $.25 for each additional page. I may ask for a copy of this form for my records.

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

Patient's Signature: _____ Date: _____

Print Legal Guardian's Name: _____

Legal Guardian's Signature: _____ Date: _____