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Authorization to use or disclose protected health information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient name _____ Date of birth _____ Account # _____

Address (street, city, state, zip code) _____ Telephone number _____

The following individual or organization is authorized to make the disclosure:

☐ The Dermatology Group, P.A.: ☐ Mt. Dora (Fax: 352-383-7112) ☐ Longwood (Fax: 407-260-0602)
☐ Orlando (Fax: 407-898-0739) ☐ Winter Park (Fax: 407-645-1082)

☐ Other (Please Specify):_____

This information may be disclosed to and used by the following individual or organization:

☐ The Dermatology Group, P.A.: ☐ Mt. Dora (Fax: 352-383-7112) ☐ Longwood (Fax: 407-260-0602)
☐ Orlando (Fax: 407-898-0739) ☐ Winter Park (Fax: 407-645-1082)

☐ Other (Please Specify):_____

Treatment dates: purpose of request:

The following information is to be disclosed: *(Please check one box for each item.)*

Yes	No		Yes	No	
☐	☐	Biopsy/Pathology Report (s)	☐	☐	Other (please specify):
☐	☐	Surgical Procedures			

_____
_____
_____

Sensitive Information: I understand that the information in my record may include information to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

a. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment.
b. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: *(If I do not specify an expiration date, event or condition, this authorization will expire in six months.)*

_____ _____
Signature of patient or legal representative Date

_____ _____
If signed by legal representative, relationship to patient Date