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THREE RIVERS DERMATOLOGY

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____Date of Birth: _____

Address: _____

Telephone Number:_____

I hereby authorize Three Rivers Dermatology to:

❑ Receive records from OR ❑ Release records to

Name of Medical Provider/Facility: _____

Address:_____City:_____State:_____Zip:_____

Phone:_____Fax:_____

Disclosed Information: (check all items to be released) ❑ **Entire Record**

❑ Progress Notes ❑ Lab Reports ❑ Pathology Reports ❑ Photos

❑ Other (please specify)_____

Covering the period(s) of care (list applicable dates of treatment)

From: _____ To:_____ OR ❑ All Dates of Service

Purpose/Use of the requested information:

❑ Personal use by patient ❑ Sharing with other health care providers

❑ Other (please describe)_____

Authorization:

I hereby authorize Three Rivers Dermatology to disclose the health information as described above. I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form. I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing Three Rivers Dermatology to release information as described above.

_____ _____ _____

Signature of Patient or Personal Representative | Print Name | Date

_____ _____

Relationship of Personal Representative to Patient | If Authorization is signed by some other than the patient, please state reason.