Patient Authorization for Release of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). If you would like someone other than yourself to be able to obtain information about you please complete this form.

PATIENT NAME:____ DOB: __________

Specific description of the information to be used or disclosed:

- o Medical Information
- o Billing Information
- o Appointment Times
- o All Information
- o Other: ____

Individuals who may disclose this information:

EAST PENN DERMATOLOGY, P.C.
1140 WELSH ROAD, SUITE 130
NORTH WALES, PA 19454
215-661-0300

Individuals who may receive and use the disclosed information (include address, fax number or phone number if necessary):

____

____

____

Information can be disclosed by: ___phone ___mail ___fax ___in person

This authorization will: ____not expire unless revoked in writing
____ expire on _______________
(date)

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you to the person(s) mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

Signature: ____ Date: __________

This authorization was signed by: ____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): ____

Form Dated
10/21/2015