

<b>Patient Name:</b> _____	<b>DOB:</b> _____
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**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

I hereby authorize Ada West Dermatology to disclose the specific information described below only for the purpose(s) and to the individual(s) also described below.

**Description of the specific information to be disclosed:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Imaging Results     | <input type="checkbox"/> Billing                 |
| <input type="checkbox"/> Visit or Progress Notes | <input type="checkbox"/> Diagnosis/Care Plan | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Lab Tests/Results       | <input type="checkbox"/> Medications         | <input type="checkbox"/> Any and All Information |

**Confidential Information to be disclosed:** *(please note this information will not be released if not checked)*

- |  |  |
|--|--|
| <input type="checkbox"/> Mental Health Information | <input type="checkbox"/> Alcohol/Drug Information    |
| <input type="checkbox"/> HIV Information           | <input type="checkbox"/> Genetic Testing Information |

**Purpose(s) for this authorization is (check all that apply):**

- Individual's Request  
 Medical Care  
 Other: \_\_\_\_\_

**Recipient(s) of information:**

Name	Date of Birth	Relationship	Phone Number

**This authorization shall remain in effect one year from the date signed or:**

- Five (5) years from date signed

**I acknowledge and understand that:**

- This authorization is giving Ada West Dermatology the right to disclose my medical information to the individual(s) listed above.
- I may inspect and/or receive a copy of the information described on this authorization by completing this form and signing below.
- I have the right to revoke this authorization at any time by providing written notice to Ada West Dermatology, except to the extent that action has already been taken based on this authorization.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA Privacy Regulations.
- This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

Signature of Patient **or** Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Representative Name (printed): \_\_\_\_\_ Authority: \_\_\_\_\_

(If signed by the patient's Personal Representative, please print name and describe authority to act for the individual.)