Ada West DERMATOLOGY

Phone: (208) 884-3376
Fax: (208) 884-0858

Patient Name: **DOB:**

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:

☐ Appointment Information ☐ Imaging ☐ Billing
☐ Visit or Progress Notes ☐ Diagnosis/Care Plan ☐ Other: _____
☐ Lab Tests/Results ☐ Medications ☐ Any/All Information:

Confidential Information to be Disclosed: (Please note, this information will only be released if checked):

☐ Mental Health Information ☐ Alcohol/Drug Information
☐ HIV Information ☐ Genetic Testing Information

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

☐ At the Request of the Individual ☐ Other: _____

Recipient(s) of information: (For other than healthcare providers)

Name	Date of Birth	Relationship	Phone Number

This authorization will remain in effect one year from 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 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.
- If PHI (Protected Health Information) is sold or used in marketing involving financial remuneration, the remuneration will be to the covered entity.

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.)