DERMATOLOGY ASSOCIATES
OF ATLANTA, P.C.

www.dermatlanta.com

Authorization for Use/Release of Health Information

(This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purposes.)

By signing this form, I authorize Dermatology Associates of Atlanta. P.C. to use, release or disclose the protected health information described below to:

Name and Address of person(s), Organization, to Whom Information Should be sent

_____

Please send this information on or about (information will not be resent without another authorization):
_____/ _____/ _____
This authorization expires upon fulfillment of request unless special circumstances noted below.
Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.):

_____

____ Copies of all medical records for the period ____/____/____ to ____/____/____

____ Copies of the information described below for the period ____/____/____ to ____/____/____

____ History & Physician Examination ____ Lab Reports ____ Reports from other Physicians

____ Other (Please Specify) _____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted disease; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released, even if occurring during dates above

_____

I understand that there may be information in these records that I would not want released.

I understand that Dermatology Associates of Atlanta, PC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Dermatology Associates of Atlanta, PC from all legal liability that may arise from this authorization.

Patient's Signature _____ Date _____

SS# _____ _____ _____ DOB ____/____/____

If the signature above is not that of the patient, I am acting for the patient because _____

My relationship to the patient is; _____
The patient, or their representative, may revoke this authorization by notifying, in writing, Dermatology Associates of Atlanta, P.C. designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization, if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information release under this authorization may be subject to redisclosure by the recipient.

Established November 2002

The Medical Quarters
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