Palmetto Dermatology, PA
Authorization to Release Health Information

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____

I authorize the practice below to release my health information:

_____

_____

_____

Please forward/release my health information to:

_____

_____

_____

The information below is provided at the request of the patient. (Describe PHI needed)

_____

_____

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to _____ _____.

_____Date _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

Revised Jan 2008

Palmetto Dermatology, PA
Authorization for Release of Information

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays ❑ Other_____
❑ Spouse	❑ Financial ❑ Medical as follows:_____ _____
❑ Parent (provide name) _____	❑ Financial ❑ Medical as follows:_____ _____
❑ Other (provide name) _____ _____	❑ Financial ❑ Medical as follows _____ _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____Date_____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

_____

Palmetto Dermatology, PA

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____