

Zitelli & Brodland, P.C.

Authorization to Use or Disclose Health Information

Patient Name: _____ Date of Birth: _____

Please print full name

1. I authorize the use or disclosure of the above named individual's health information by The Skin Surgery Center as described below.

2. The type of information to be used or disclosed is as follows:

My complete medical records or check the appropriate boxes below,

- Checkboxes for Clinic Note, Progress Note, Anesthesia/Sedation Record, Other (Specify below), Prescription History, Consultation Note, Bill for Service, Laboratory Result, Radiology Report, History and Physical Report, Operative/Procedure Report, Pathology Report, Paper copies of records (otherwise records will be on disc)

The above information can be released from the date of _____ through _____ Or the period of time encompassing all dates of service at The Skin Surgery Center.

3. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.

4. The information identified above may be used or disclosed to and/ or requested from the following individual(s) or organization(s):

Name of Organization or Individual _____

Address _____

Phone Number _____

Fax Number _____

5. This information for which I am authorizing disclosure will be used for the following purpose: my personal use, sharing with other health care providers, workman's compensation, other: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. This authorization will expire on _____ (Date) or is valid as long as I am a patient of this practice. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.

8. I understand that once the above information is disclosed, the recipient may redisclose it, and the federal privacy laws or regulations may not protect the information.

9. I understand the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment.

Signature of patient or legal representative _____

Date _____

If signed by legal representative, relationship to patient _____

Signature of witness _____

Date _____