Authorization For The Use Or Release Of Protected Health Information

DERM|sa
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Name Include Maiden Name Other Name That Records May Be Under

Address/City/State/Zip

Phone Date Of Birth

I Hereby Authorize Release To

☐ Complete Health Records ☐ Laboratory Reports
☐ Operative Report ☐ Pathology Reports
☐ Other_____ ☐ Progress Notes

I authorize this information to be faxed ☐ Yes ☐ No Fax# _____

Date_____to_____

_____(Initial) I understand that this authorization may include information relating to:
Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV)
Psychiatric Care
Treatment for alcohol and/or drug abuse
Genetic Testing

The date, extent or condition upon which this authorization expires is_____.
(not to exceed 24 months except for research purposes. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other than Dermatology Associates of San Antonio and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility, or lack thereof of such incorporated records). I expressly request release of all records maintained by Dermatology Associates of San Antonio concerning me including incorporated records. I acknowledge that Dermatology Associates of San Antonio has no and assumes no duty to me regarding the content of or omission from such incorporated records.

I hereby release Dermatology Associates of San Antonio and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. Dermatology Associates is not responsible for completeness, legibility, or omission caused by coping of any medical records from another institution.

Printed name of patient's representative Relationship

Signature of patient or patient's representative Date

This information, which has been disclosed to you from confidential records, is protected by federal law. Federal law regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of the law shall be fined or imprisoned.