SANOVA
DERMATOLOGY

Authorization for Release of Protected Health Information (PHI)

Patient Name | Date of Birth

Address | Telephone Number

I hereby authorize (name of facility/provider releasing information) to disclose the above-named individual's health information:

Name (facility releasing information) Address | City | State | Zip

Telephone Number | Fax Number

Date(s) of Service Requested (if known) or Provider: _____

Description of Information to be released: (check all that apply)

___ Progress Notes
___ Consultations
___ Most recent history & physical
___ Immunization record
___ Other _____
___ Laboratory Reports
___ Radiology/Imaging reports
___ Radiology films
___ Two-way verbal exchange of communication
___ Entire Medical record

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization (receiving the information)

Name (Facility receiving information) Address | City | State | Zip

Telephone Number | Fax Number

Description of the purpose of the use and/or disclosure: (check one)

___ Continuing Care
___ Collaboration of Care
___ Confidential Legal purposes
___ Second Opinion
___ Emergency/Acute Care
___ Personal Use
___ Social Security/Disability
___ Insurance
___ Other _____
___ Marketing – if this request is for marketing purposes, Sanova Dermatology may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient's protected health information (PHI).

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. Sanova Dermatology may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (day or event).

I further understand that I may revoke this authorization at any time by notifying Sanova Dermatology. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect my actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient or Patient's Representative | Date