PRINCE WILLIAM DERMATOLOGY

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Authorization to Use or Disclose Protected Health Information (*Please Print)*

I hereby authorize use or disclosure of the named individual's health information as described below:

Name of patient _____ Date of Birth _____/_____/_____

Address _____

Social Security Number (optional) _____ Patient telephone number _____

The following individual or organization is authorized to make disclosure:

☐ Prince William Dermatology may disclose protected health information pertaining to the above named patient **to the individual or organization listed below.**

☐ The individual listed below may disclose Protected Health Information **to Prince William Dermatology**.

Name or individual or organization :_____

Address of individual or organization:_____

Phone/fax of individual or organization: Phone_____Fax _____

Records may be: _____ Mailed _____ Faxed _____ Sent securely via patient portal to patient

Purpose of Disclosure: ____ Patient Access _____ Health care provider ____ Insurance _____ Attorney _____
Other (please describe) _____

Information to be disclosed: ____ Entire record ____ Office Visit Notes ____ Financial records ____ Pathology reports ____ Lab reports ___ Other: _____ For treatment dates: _____ to _____

This is a: ___ One time disclosure ___ Continuing disclosure for 12 months

I have the right to revoke this authorization at any time. Revocation is not effective in cases in which the information has already been disclosed

I (or someone authorized to act on my behalf) is entitled to a copy of this authorization and the requestor may be provided a copy of this authorization.

I am entitled to inspect my records and may request a copy of the protected health information to be disclosed as described in this document. A records copying fee of $10 for fewer than 10 pages and $15 for more than 10 pages is applicable.

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 state of federal law. I hereby release Prince William Dermatology from any legal responsibility or liability for disclosure that may arise as a result of use of any information contained in the Protected Health Information.

Authorization of disclosure of protected health information is voluntary. I may refuse to sign this authorization and my treatment is not conditioned on signing.

_____ _____

Signature of patient or Personal Representative **Date**