Authorization to Release Medical Information

Patient's Name: _____

DOB: _____ **Account #:** _____

Address:_____

1. I authorize the use or disclosure of the above named individual's health information, as described below.

2. **Affiliated Dermatologists & Dermatologic Surgeons, P.A.** is authorized to make the disclosure set forth below.

3. The information may be disclosed to, and used by, the following individuals or organizations:

   Name(s):_____
   Address: _____

   For the following purpose(s):_____
   _____

4. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose(s) and may include the following items (unless crossed out by me).

   Drug and Alcohol Abuse information.
   Information regarding Human Immunodeficiency Virus (HIV), including laboratory test results.
   Diagnosis of AIDS or ARC, if applicable.
   History and Physical examination.
   Consultations.
   Genetic testing and counseling, if applicable.
   Diagnostic testing, excluding HIV testing.
   Discharge summary.
   Psychosocial history.
   Treatment recommendations.
   Other (specify):_____

5. This authorization may be revoked by me at any time except to the extent that Affiliated Dermatologists & Dermatologic Surgeons, P.A. has already acted in reliance on this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to the HIPAA Privacy Officer, Affiliated Dermatologists & Dermatologic Surgeons, P.A., 182 South Street, Morristown, New Jersey 07960. If not revoked by me, this consent will terminate on:_____.

6. I have a right to inspect the information to be disclosed.

7. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

8. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule.

Signature of Patient or Legal Representative:_____

If signed by a Legal Representative, relationship to patient:_____

Date:_____