

Patient Name: _____ DOB: _____

Authorization to Release Information

We may need to contact you by telephone about medical information and billing. Please complete the following:

I prefer to be contacted at: HOME # _____

CELL # _____

You may leave messages on my answering machine or voicemail at:

_____ Home _____ Cell

Many of our patients allow family members such as their spouse, parents, or others to request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below.

I authorize/allow Saybrook Dermatology, LLC to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

Saybrook Dermatology, LLC will make reasonable efforts to accommodate this request. You can request a change at any time. Please allow 10 days for the updated request to be processed. Protected Health Information is only released in compliance with federal and state privacy regulations. I understand that the information disclosed to any above recipients is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. I understand that I may revoke this authorization in writing at any time except to the extent that Saybrook Dermatology, LLC has already taken action in reliance on the authorization.

Patient Signature: _____ Date: _____