

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Privacy Officer: Heather Larson

I hereby authorize _____
to release information from my medical records to:

Name: _____

Address: _____

I request that the information to be used or disclosed consist of the following : *(If this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes).*

I understand that this health information may include STD or HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form I am authorizing such information to be disclosed.

I understand that the disclosed information may be re-disclosed in accordance with the law and may no longer be protected by the federal privacy standards. Further, I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by federal privacy standards. However, other state and federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

This request is for the following reason:

- Insurance Change
- Relocating
- Changing Doctors
- Other: _____

All records of treatment are the legal property of Saybrook Dermatology, LLC. I understand that I will be responsible for any administrative fees associated with the copying of my records.

INDIVIDUAL’S RIGHT RELATING TO THIS AUTHORIZATION:

I understand that I have a right to receive a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that Saybrook Dermatology, LLC may not condition treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying Saybrook Dermatology, LLC in writing of my revocation. I am aware that my revocation will not be effective as to uses and/or disclosures of the health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until _____. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature

Date

Print

Date of Birth