dermatology associates OF LINCOLN

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# PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

| Patient Name: | Date of Birth: | Account #: |
|---|---|---|
| Patient Address: | Patient City, State Zip: | |

**THIS WILL AUTHORIZE:**

Name of Person or Organization _____

Address, City, State Zip _____

**TO RELEASE INFORMATION TO:**

Name of Person or Organization _____

Address, City, State Zip _____

**Release the following information:**

□ All Medical Records □ Lab Reports □ Pathology Reports □ Treatment Plan
□ Allergies □ Medications □ Procedure Notes □ Visit Notes
□ Other _____

**Omit the following information:**

□ HIV Records □ Substance Abuse Records
□ Mental Health Records □ Other _____

**Purpose of Release:**

□ Insurance Purposes □ Legal □ Physician Change □ Treatment/Referral
□ Other _____

**Method of Delivery:**

□ Mail □ Fax ( ) _____-_____ □ I will pick up

**Dermatology Associates of Lincoln will not receive payment or other remuneration from a third party in exchange for using or disclosing information. You do not have to sign this authorization in order to receive treatment from Dermatology Associates of Lincoln. When this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. You have the right to revoke this authorization at any time by providing a written request to the Dermatology Associates of Lincoln Privacy Officer, except to the extent that we have already acted in reliance upon this authorization.**

I authorize the use and disclosure of the medical records and health information indicated above:

_____ _____

**Signature of Patient or Parent/Guardian** **Date**

_____ _____

**Parent/Guardian Name (Printed)** **Relationship to Patient**



Updated 12/16/2020