dermatology associates OF LINCOLN

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AUTHORIZATION FOR USE AND DISCLOSURE OF PHI
(MEDICAL RECORD RELEASE)

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

THE INFORMATION IS TO BE DISCLOSED BY:

Name of Person or Organization _____

Address, City, State Zip _____

THE INFORMATION IS TO BE PROVIDED TO:

Name of Person or Organization _____

Address, City, State Zip _____

Release the following information:

□ Entire Record □ Lab □ Pathology □ Visit Notes □ Procedure Notes

□ Allergies □ Medications □ Billing □ Other _____

Omit the following information:

□ HIV/AIDs Treatment □ Substance Use Treatment □ Mental Health Treatment □ Other _____

Purpose of Release:

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

Method of Delivery:

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

- I understand that my signature on this form allows Dermatology Associates of Lincoln to release my protected information to a person or organization that I choose. I can revoke this authorization at any time by submitting a written request to the Privacy Officer. Revoking this authorization will not affect any action taken prior to receipt of my written request. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. _____
- I understand that if the person(s)/organization(s) I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release my protected health information, and it may no longer be protected by federal privacy laws.
- I understand that Dermatology Associates of Lincoln will not condition treatment or eligibility for care on my providing this authorization.
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- **I authorize the use and disclosure of the medical records and health information indicated above:**

_____ _____

Signature of Patient or Parent/Legal Guardian Date

_____ _____

Parent/Legal Guardian Name (Printed) Relationship to Patient

Updated 4/11/2025