Authorization for use or Disclosure of Medical Record

Medical Record #

Patient Information

Patient Full Name:_____ Date of Birth:_____
Patient Address:_____ Home Phone:_____
City:_____ State:_____ Zip:_____ Work Phone:_____

Release Information To

I authorize West Dermatology to release my medical records to the following:

☐ Mail Copies To *(address below)* ☐ Hold for Patient Pick-up *(address below)*

Name/Facility:_____ Attention:_____
Address:_____
City:_____ State:_____ Zip:_____ Phone:_____

Purpose of Request: ○ *Personal ○ Continuing Care ○ *Other_____

Information to be Released

PLEASE BE SPECIFIC - include dates of treatment & provider name if applicable.

_____ Date(s) of Treatment:_____

_____ Date(s) of Treatment:_____

_____ Date(s) of Treatment:_____

○ I have been granted Power of Attorney or Guardianship of the patient as indicated by the attached document.

Authorization for Release of Statutorily Protected Information

DO NOT Leave This Section Blank - The requested medical record MAY or MAY NOT contain information that is statutorily protected. You must check either "Yes" or "No" and initial each category for West Dermatology to properly process your medical record request.

	Release Records? Check one		
	Yes	or **No**	
Mental Health	☐	☐	Initial Here:_____
HIV Tests & Related Information	☐	☐	Initial Here:_____
Alcohol and/or Substance Abuse	☐	☐	Initial Here:_____

Please confirm that you have checked "Yes" or "No" and initialed all 3 protected information categories above even if they do not necessarily apply to the patient's records. If information is not released and/or form is incomplete, West Dermatology may be unable to fulfill this request.

Sensitive Information

Please check or indicate below any sensitive information that you **DO NOT** want released.

☐ Abortion ☐ Sexually Transmitted Disease ☐ AIDS/ARC
☐ Genetic ☐ Domestic Sexual Assault ☐ Other(s)_____

This authorization is effective for one year from the date of signing unless a different date is specified here:_____.
This authorization maybe revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.
A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.
NOTICE: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____
Patient's Signature/Date

Know Your Privacy Rights

refer to the HIPAA
"PRIVACY NOTICE"

_____
Parent/Legally Recognized Representative Signature/Relationship to Patient**/Date

_____
Witness/Date

**By my signature, I attest that I am the legally recognized representative of the above-mentioned patient in accordance with the following _____. The information release pursuant to this Authorization may be disclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. West Dermatology will not condition treatment or payment of the provision of this Authorization. Patient does have a right to receive a copy of this form.

PLEASE FAX BACK TO (702) 853-6922