

Authorization for Use or Disclosure of Medical Record Information

Medical Record # _____

Patient Information

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

Health Information Released TO:

Platinum Dermatology Partners and Its Affiliates

Other:

Person/Organization: _____

Street Address: _____

City: _____

State/Zip Code: _____

Fax: _____

Phone: _____

Health Information Released FROM:

Platinum Dermatology Partners and Its Affiliates

Other:

Person/Organization: _____

Street Address: _____

City: _____

State/Zip Code: _____

Fax: _____

Phone: _____

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 Platinum Dermatology Partners 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, Platinum Dermatology Partners 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

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

refer to the HIPAA
"PRIVACY NOTICE"

 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. Platinum Dermatology Partners 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 (866) 957-1617