

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Provider in possession of PHI: _____

Address: _____

Individual or Entity To Whom
the PHI is to be Released:

Name: _____

Address: _____

Email

Description of PHI to be Used, Disclosed, or Released (check all that apply):

- My demographic information. (Check all that apply)
 - Name Street Address City/State/Zip Home Telephone
 - Birthdate Age Gender Business Telephone
 - Race Ethnicity Email Address URL/IP Address
- My billing and/or insurance information. Billing information Insurance information
- Medical data/information relating to:
 - Visits/Encounters/Dates of Service between _____ and _____.

Date *Date*
 - Medical conditions, including: _____
 - Procedures relating to: _____
 - Specially protected health information:
 - HIV/AIDS information
 - Substance Abuse Treatment Records
 - Other: _____
 - Other: _____
- My entire medical record (please provide the reason your entire medical record is necessary)
 - _____
 - _____

This Authorization is given for the sole purpose of: _____
(Reason for Use, Disclosure, or Release)

This Authorization will expire: _____
(Specific expiration date or timeframe for expiration)

As the person signing this Authorization, I understand that I am giving my permission to and authorizing the above-named Provider or other third party to release my confidential health information.

Neither Pearland Dermatology nor the recipient of my records has conditioned my treatment, payment, enrollment or eligibility for benefits on my signing this Authorization.

I understand I have the right to revoke this Authorization at any time, but my revocation is not effective until delivered in writing to the individual or entity in possession of my records. The individual or entity in possession of my records may have acted on my original Authorization in good faith before receiving my revocation.

I further understand Pearland Dermatology is not responsible for any disclosures of my health information that may occur from the recipient of my records once Pearland Dermatology provides my confidential health information in response to this Authorization.

(Date)

(Patient's signature)

OR

(Signature of patient's representative)

(Relationship to patient)