AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____
Social Security Number: __ _____ Date of Birth: _____

Provider in possession of PHI: _____ _____
Address: _____
_____
Fax: _____

Individual or Entity To Whom the PHI is to be Released:
Name: _____
Address: _____
_____
Fax: _____
Email _____

Preferred Method of Delivery: (PLEASE INDICATE)
- ☐ US Mail to above address: _____
- ☐ Fax to _____
- ☐ Email _____(only if able to do so in compliance with the HIPAA)
- ☐ Will pick up _____

Please note that we charge a fee of $ 25.00 to access and prepare Medical Records up to 25 pages. Should your record consist of additional documentation, additional per page fees will apply.

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 DermSurgery Associates P.A. 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 DSA Surgery Center, Inc. / DermSurgery Associates P.A. is not responsible for any disclosures of my health information that may occur from the recipient of my records once DSA Surgery Center, Inc. provides my confidential health information in response to this Authorization.

_____ _____
(Date) *(Patient's signature)*

OR

_____
(Signature of patient's representative)

_____
(Relationship to patient)