INSTITUTE OF DERMATOLOGY AND OCULOPLASTIC SURGERY

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

_____
Name of Person/Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

To Release my Information To:

_____
Name of Person/Organization Receiving Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

_____Complete Medical Record
_____Medical Records for Specific Dates of Service (please list) from_____ to _____
_____Other (please list) _____

This authorization remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X_____ X_____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

_____
Description of Personal Representative's Authority (attach necessary documentation)

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Date Sent: _____ **By:** _____ **Via:** _____