Gary Mendese, MD
Stephen Moyer, DO
Robert Murgia, DO
Daniel O'Connor, MD
Todd Wechter, MD
Neera Nathan, MD

Molly Plovanich, MD
Alaina Iannazzi, PA-C
Rachel York, PA-C
Nathan Hand, PA-C
Michelle Ryder, PA-C
Heather Bigos, PA-C

Stephanie Grant, NP
Jane Tallent, NP
Christine Horrigan, NP
Lindsey Ramsey, RN
Brooke Comire, RN

Protected Health Information Release Authorization

Patient Name: ______________________________ DOB: ______________________

This will authorize: ______________________________ , to use and/or disclose my protected
(Name of Entity)
health information for the following purpose: ______________________________

Name of person or entity **releasing** information:

____
Name

____
Street Address

____
City, State, Zip

____
Phone Number Fax Number

Name of entity **receiving** information:

Attn: ______________________
Dermatology & Skin Health

____	Dover, NH	Fax: 603-742-8668
____	Newington, NH	Fax: 603-742-8668
____	Londonderry, NH	Fax: 603-742-8668
____	Bedford, NH	Fax: 603-742-8668
____	Peabody, MA	Fax: 978-595-5026

Information to be disclosed

- Complete Medical Record **(This may include, as applicable, information related to mental health, drug or alcohol treatment, genetic testing, HIV/AIDS, and psychotherapy notes.)**

OR

- Records from the following dates: ______________________ to ______________________.

OR

- I only want the following parts of my medical record to be disclosed, I will list them here:

____

____

If the choice I made above contains certain information I do not want disclosed, I will list it below:

____

____

Dermskinhealth.com

784 Central Avenue
Dover, NH 03820

2299 Woodbury Ave., Ste. 3
Newington, NH 03801

50 Michels Way, Suite 202
Londonderry, NH 03053

160 South River Road
Bedford, NH 03110

23 Centennial Drive
Peabody, MA 01960

P: 603-742-5556 F: 603-742-8668

Patient Name: ____ DOB: _______________________

- I understand that I may refuse to sign this authorization. The Entity listed on page one, releasing my information, will not refuse to treat me based on my refusal to sign the authorization, unless the sole purpose of the requested treatment is to create records for disclosure to someone else. For example, the Practice may refuse to perform a pre-employment physical for me if I refuse to authorize the release of information obtained during that physical to my employer.

- You may revoke this authorization at any time, in writing, except to the extent that we have already relied upon it in making a disclosure. Your written revocation will become effective when we receive it. If you are providing this authorization to obtain insurance coverage, you may not have the right to revoke the authorization in the future to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this authorization, please send your written request to: the Entity listed on page one.

- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law will no longer protect it.

- I understand that I have the right to inspect or receive a copy of the information I am consenting to release.

- Once this authorization has expired, we will no longer use or disclose your health information for the purpose listed in this authorization unless you sign a new form. **This authorization expires:**

a. On the following date: _____ / _____/ _____.
b. When the following event occurs: ____
c. _____ Check here if this authorization is for the purpose of permitted use or disclosure of PHI for the purpose of research - in which case this Authorization does not expire.
d. If none of (a) through (b) is complete above, this Authorization will expire 12 months from the date this form is signed.

____ ______________________________ ____________
Signature of Patient or Legal Representative/Guardian | Printed Name | Date

____
Authority or Relationship of Representative (Attach copy of documentation of authority)

To Recipient of this authorization: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. If the information is drug or alcohol abuse treatment information covered by 42 CFR part 2, federal law prohibits you from making any further disclosures of this information without the specific writing authorization to which it pertains.

Authority: This form is designed to comply with CFR 45 Section 164.508

Copy Provided: I have received a copy of my authorization to release my PHI.

Initial of signer: ___________ Date: _____ /_____ /_____