DSH DERMATOLOGY & SKIN HEALTH
Where Exceptional Care Comes First

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name_____ D.O.B._____ MR#_____

I give my permission to share my protected health information. Please enter where you would like information sent from and to whom you would like the information sent to.

From:

Name: Dermatology & Skin Health
Address: 784 Central Ave
Dover, NH 03820
Phone: 603-742-5556 Fax: 603-742-8668

To:

Name: _____
Address: _____
_____
Phone: _____ Fax: _____

Purpose: ☐Medical Care ☐ Insurance ☐Legal Matter ☐Personal ☐School ☐Transfer of Care

Information to Be Disclosed:
Note: Your choice of information to be disclosed may include, information related to mental health, drug or alcohol treatment, genetic testing, and HIV/AIDS.

☐ Records for specific dates: _____ to _____;

OR
☐ Complete Medical Record including: Office Notes, Lab Reports, Pathology Reports
OR
☐ If the choice I made above contains certain information I do not want disclosed, I will list it below:
_____

Method of Delivery: ☐ Mail to receiving entity above ☐ I will pick up
☐ Designee will pick up (specify below) ☐ Other _____

To be completed if Designee will pick up records:

I allow _____ [print name], my designee, to pick up the medical records identified above since I am unable to do so myself.

- ☐ One time only – once my designee picks up my medical records, that person may not pick up my medical records in the future unless I sign another copy of this document.
- ☐ Indefinitely – my designee may pick up my medical records until I revoke the authority of my designee or until this PHI Release form expires or is revoked by me.

Patient Name _____ D.O.B._____ MR#_____

- I MAY REFUSE TO SIGN THIS AUTHORIZATION. Dermatology & Skin Health, and its related entities, 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.

- I 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: **Dermatology & Skin Health, ATTN: Office Manager, 784 Central Ave, Dover, NH 03820**

- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law may 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 within the established policies of Dermatology & Skin Health, and its related entities.

- This authorization will automatically expire **12 months from the date signed** unless limited to the following date/event _____.

_____ _____ _____

Printed Name | Signature of Patient or Legal Representative/Guardian **(Legal Handwritten Signature Accepted Only)** | 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 written authorization to which it pertains.

AUTHORITY: This form is designed to comply with CFR 45 Sec. 164.508.

A copy of this authorization must be provided to the patient.

For Office use Only:

Request Processed and Records Sent with Patient By: Staff Initials_____ Date_____

For Medical Information use only:

☐ Patient picked up ☐ Mailed to patient ☐ Mailed to receiving entity ☐ Other_____

Date: _____

Completed By: Staff Initials_____ Date_____

☐ ***A copy of this signed authorization has been included with the records provided to the patient.***

For Designees/Patients picking up records only (signature will be obtained by Medical Information at time of pick up):

Signature _____ Printed Name _____ Date_____