South Shore Dermatology Physicians, PC

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize_____ to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Name _____ Date of Birth _____

Address _____
Street City State Zip Code

3. Information to be disclosed to _____
Name
Address _____
Street City State Zip Code

4. Disclose the following information for treatment dates _____ to _____ OR

_____ Complete Records _____ Laboratory _____ Pathology

5. The above information is disclosed for the following purposes:

_____ Medical Care _____ Personal _____ Legal _____ Insurance _____ Other

6. I understand I may revoke this authorization at any time by requesting such of the above referenced physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

7. This authorization expires on (upon) _____
Date or Event

_____ _____
Signature of patient or legal representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient or authority to act for patient

This authorization shall be deemed invalid unless all numbered entries are completed