

## Authorization for Use or Disclosure of Medical Record Information

Medical Record # \_\_\_\_\_

**Patient Information**

 Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Health Information Released TO:**
 Platinum Dermatology Partners and Its Affiliates

 Other:

Person/Organization: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Zip Code: \_\_\_\_\_

Fax: \_\_\_\_\_

Phone: \_\_\_\_\_

**Health Information Released FROM:**
 Platinum Dermatology Partners and Its Affiliates

 Other:

Person/Organization: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Zip Code: \_\_\_\_\_

Fax: \_\_\_\_\_

Phone: \_\_\_\_\_

**Information to be Released**
**PLEASE BE SPECIFIC** - include dates of treatment & provider name if applicable.

 \_\_\_\_\_ Date(s) of Treatment: \_\_\_\_\_  
 \_\_\_\_\_ Date(s) of Treatment: \_\_\_\_\_  
 \_\_\_\_\_ Date(s) of Treatment: \_\_\_\_\_

 I have been granted Power of Attorney or Guardianship of the patient as indicated by the attached document.

**Authorization for Release of Statutorily Protected Information**
**DO NOT Leave This Section Blank** - The requested medical record MAY or MAY NOT contain information that is statutorily protected. You must check either "Yes" or "No" and initial each category for Platinum Dermatology Partners to properly process your medical record request.

## Release Records? Check one

Yes or No

**Mental Health**
 Yes  No Initial Here: \_\_\_\_\_

**HIV Tests & Related Information**
 Yes  No Initial Here: \_\_\_\_\_

**Alcohol and/or Substance Abuse**
 Yes  No Initial Here: \_\_\_\_\_


Please confirm that you have checked "Yes" or "No" and initialed all 3 protected information categories above even if they do not necessarily apply to the patient's records. If information is not released and/or form is incomplete, Platinum Dermatology Partners may be unable to fulfill this request.

**Sensitive Information**

 Please check or indicate below any sensitive information that you **DO NOT** want released.

 Abortion

 Sexually Transmitted Disease

 AIDS/ARC

 Genetic

 Domestic Sexual Assault

 Other(s) \_\_\_\_\_

 This authorization is effective for one year from the date of signing unless a different date is specified here: \_\_\_\_\_  
 This authorization maybe revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

**NOTICE:** Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

 \_\_\_\_\_  
 Patient's Signature/Date

**Know Your Privacy Rights**

 \_\_\_\_\_  
 Parent/Legally Recognized Representative Signature/Relationship to Patient\*\*/Date

 refer to the HIPAA  
**"PRIVACY NOTICE"**

 \_\_\_\_\_  
 Witness/Date

\*\*By my signature, I attest that I am the legally recognized representative of the above-mentioned patient in accordance with the following \_\_\_\_\_. The information release pursuant to this Authorization may be disclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Platinum Dermatology Partners will not condition treatment or payment of the provision of this Authorization. Patient does have a right to receive a copy of this form.

**PLEASE FAX BACK TO (866) 957-1617**