Dermatology Associates, P.C.
95 Chapel Street
Norwood, MA 02062
781-762-5858

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

- ❑ I hereby authorize Dermatology Associates, P.C. to disclose the following health information to: _____
- ❑ I hereby authorize _____ to disclose the following health information to Dermatology Associates, P.C.

Specific information to be released:

1. Information to be disclosed:

   - ❑ Medical record from this date _____to this date_____.

   - ❑ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

   Comments:_____

   _____

2. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, Dermatology Associates, P.C. will release such information about me if it exists.

   - ❑ HIV/AIDS infection
   - ❑ Genetic information
   - ❑ Mental Health
   - ☐ Sexually transmitted diseases
   - ☐ Treatment for alcohol and/or drug abuse

3. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

4. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying Dermatology

Associates, P.C.. I understand that any previously disclosed information would not be subject to my revocation request.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here:

_____

_____

This form must be fully complete before signing.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____

Print Patient's Name

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient