

**Authorization for Disclosure of Patient Health Information (PHI)**

\_\_\_\_\_  
 Patient's last name                      First name                      Middle                      Date of birth                      Former name, if any  
 \_\_\_\_\_  
 Social Security number                      Phone number

**1. I authorize SkinCare Physicians to use and/or disclose certain protected health information (PHI) about me to the following person or company:**

\_\_\_\_\_

\_\_\_\_\_

**2. I permit SkinCare Physicians to use and disclose the following PHI about me (specifically describe PHI to be used or disclosed, such as dates of service, type of services, level of detail to be released, origin of information etc.)**

\_\_\_\_\_

**3. Information to be released:**                      **Via:**     Mail                       pick up                       Fax # \_\_\_\_\_

entire medical record                       HIV (AIDS) related                       diagnostic test results                       photographs

only those portions pertaining to: \_\_\_\_\_

**4. This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.**

I DO consent to have this information disclosed.     I DO NOT consent.

**5. This information will be used or disclosed for the following purposes:**

further medical care                       payment of insurance claim                       legal investigation

applying for insurance                       disability determination                       at the request of the individual

other – specify: \_\_\_\_\_

**6. This authorization is valid for 90 days from the date signed. Please complete line below if requesting authorization to expire PRIOR to 90 days:**

\_\_\_\_\_

**I authorize release of my PHI as specified above. I do not have to sign this authorization in order to receive treatment from Skincare Physicians. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. I understand that the only way to cancel this request, except where information has already been released, is to notify SkinCare Physicians of Chestnut Hill Medical Records Department in writing. I understand that the practice may receive payment or other remuneration from a third party, or charge for copying services, in exchange for disclosing PHI. I also hereby release SkinCare Physicians of Chestnut Hill from all legal responsibility and liability that may arise from the release of information authorized by this document.**

**7. Signature of patient:** \_\_\_\_\_                      **Date:** \_\_\_\_\_

If signed by anyone other than the patient, state relationship and/or reason and legal authority to do so (please include signature of witness):

Patient is:     minor                       incompetent                       disabled                       deceased  
 Legal authority:                       legal guardian                       next of kin of deceased

**8. Signature of witness:** \_\_\_\_\_                      **Date:** \_\_\_\_\_

**9. Written name of witness:** \_\_\_\_\_

<b>10. Medical Records Department Use</b>	
Date received: _____	Date released: _____
Processed by: _____	
<input type="checkbox"/> sent by mail <input type="checkbox"/> picked up in person <input type="checkbox"/> faxed (confirmation sheet attached if available)	