SKINCARE PHYSICIANS®
1244 Boylston Street, Suite 302, Chestnut Hill, MA 02467
Phone: (617) 848-1644 Fax: (617) 848-1627

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. By signing this authorization, I authorize SkinCare Physicians to use and/or disclose certain protected health information (PHI) about me to:

_____
Name Address

2. This authorization permits SkinCare Physicians to use and disclose the following identifiable health information 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 one time access to the medical records, and expires on (please complete) _____ (date or defined event. If not specified, expires 90 (ninety) days from date signed.) 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 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 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:
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: _____

10. Medical Records Department Use

Date received: _____
Processed by: _____ Date released: _____
☐ sent by mail ☐ picked up in person ☐ faxed (confirmation sheet attached if available)