FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

Authorization for Disclosure of Health Information

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Information:

Name _____ Address _____ City _____ State _____ Zip _____

Date of Birth:____/____/_____ Phone Number_____Previous Name _____

Authorizes:

Name of Health Care Provider / Plan / Other _____ Address _____ City _____ State _____ Zip _____

Phone Number_____Fax Number _____

To Disclose To:

☐ **Self** *Delivery Options:* ☐ Pick Up ☐ Mail to Address Above ☐ Email to me (address): _____

☐ **To be picked up by**, I hereby authorize_____to pick up my records. (Photo ID required.)

☐ **Send to:** Name of Health Care Provider / Plan /Other_____

☐ By Mail (Address) _____

☐ By Fax (To #)_____ ☐ By Email (Address) _____

Information to be released:

☐ Office Visit Records ☐ Diagnostic Test Results ☐ Operative Reports
☐ Other Describe: _____

Release records from the time period of_____to _____ ***If left blank, only the past (2) years will be disclosed.***

Unless checked or listed below, I understand that the following information may be released (as defined by applicable state and federal laws).
Check and/or list if you do *not* want to disclose: ☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities
☐ Genetic Testing/Counseling ☐ Other_____

Expiration:

This authorization is valid for_____(Maximum of ONE year. If left blank, authorization will expire in one year from the date signed.)

Purpose(s) of the disclosure:

(check all that apply) ☐ Continued Care ☐ Insurance ☐ Legal ☐ Disability Determination
☐ Second Opinion ☐ Personal ☐ Other Describe: _____

Your Rights with Respect to this Authorization:

I understand that I have a right to inspect and receive a copy of the material to be disclosed. I understand that written notification is necessary to revoke this authorization, except to the extent that information may have been released before receipt of this notice. My decision to sign this authorization will not affect my treatment. If this information is being disclosed to an individual or entity that is not a health care provider or health plan, it may be subject to re-disclosure and no longer protected. A photocopy/facsimile or scanned copy of this form is valid as the original.

_____ _____
Signature of Patient /Legal Representative Date
(Form MUST be completed before signing)

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ A Minor ☐ Legally incompetent or incapacitated ☐ Deceased
2. Legal authority: ☐ Parent ☐ Legal guardian ☐ Next of kin/executor of deceased ☐ Activated POA for Health Care

*By signing above, I hereby declare that I have not been denied physical placement of this child.

Please return this completed form in person to any Forefront location, via fax to 920-663-0817 or email to: medicalrecords@forefrontderm.com

Updated 5/22/2019

For Office Use Only:
Signature Verified ☐ *Yes* ☐ *No*
Completed by: _____ *Date:* _____
# of pages released: _____