PREMIER DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC
A FOREFRONT DERMATOLOGY PRACTICE

# 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

## 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 11/30/2017*

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