PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

FROM HORVATH DERMATOLOGY ASSOCIATES

Name_____

Date of Birth: _____ **Social Security Number:** _____

Entity Requested to Release Information:

Practice Name: **HORVATH DERMATOLOGY ASSOCIATES**

Address: **110 FORT COUCH ROAD Suite 203, PITTSBURGH, PA 15241**

Phone: **412-831-3300** **Fax: 412-831-3301**

Purpose of request (who will be authorized to receive information) – I authorize the entity identified above to disclose or provide protected health information, about me, to (please identify entity to:

Entity Authorized to Receive Information:

Name (Entity or Individual): _____

Address: _____

Phone: _____ Fax: _____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person or person identified above:

Entire patient record; **or**. Check**only** those items of the record to be disclosed:

[] Lab results [] Pathology results[] Office notes [] other: _____

Purpose of Disclosure (please describe the purpose of the disclosure or check patient request):

[ ] Patient Request[]other (please specify): _____

Expirations or termination of authorization: This authorization will expire one yearfrom the date the form is signed, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the entities or person(s) you have listed to receive your protected health information (PHI). Therefore, your PHI disclosed under this authorization will no longer be the responsibility of the practice releasing the PHI and, depending upon the entity receiving it, may no longer be protected by the requirements of the Privacy Rule.

_____ _____

patient / guardian signature *date*

Copies of signed authorizations are available upon request.