Alta Dermatology
For the health and beauty of your skin

Authorization for Use or Disclosure of Health Information

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

Patient Name: _____ DOB: ____/____/_____

Address: _____

Phone: _____

Release from: _____ Release to: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Address: _____ Address: _____

Date of records requested: From: _____ To: _____

The following information is to be released:

- ☐ Assessment/ History and Physical
- ☐ Copy of films/ imaging Study
- ☐ Lab Results
- ☐ Diagnostic Studies
- ☐ X- Ray Reports
- ☐ Progress Notes
- ☐ All the above
- ☐ Other

Records shall be used for: Acute Care ☐ Continuation of care ☐ Second opinion ☐

Records shall be delivered by: Fax ☐ U.S. Mail ☐ Other ☐

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of health information that I am being asked to allow the use of disclosure of. I may revoke this authorization at anytime, but I must do so in writing and submit it to the following address: _____

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be re- disclosed by the recipient. If this box ☐ is checked, the requester will receive compensation for the use or disclosure of my information.

SIGNATURE

Patient Signature: _____ Date: ____/____/_____

Patient's Legal Representative Signature: _____ Date: ____/____/_____

Printed Name of Legal Representative: _____