Primary Care Physician: ______________________________________

Protected Health Information Release:

In compliance with **HIPAA** regulations and in order to facilitate requests for your protected health information, please complete the following.

I authorize the person(s) listed below to have access to any of my protected health information, including HIV, drug and alcohol abuse and psychiatric records. **Melbourne Dermatology Center** is permitted to share with them test results and information disclosed during my office visits. For copies of medical records, I understand that I will need to sign a separate authorization. Please list below, those individuals that you wish to receive your protected health information.

______________________________ ______________________

Full name Relationship

______________________________ ______________________

Full name Relationship

This office is required to keep your signature on file authorizing us to file claims for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following.

Name of Insurance Company: ____

Policy Holder Name: ____________________________Relationship to you_____________

Policy Holder’s Date of Birth___/_____/_____

I understand that I will update Melbourne Dermatology Center with any changes in the above listed contact information. I understand and direct that this authorization will remain in effect until is revoked by me in writing.

______________________________ ________________

Patient Name Date

____

Patient Signature