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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Name and address of who will provide the information: _____

_____

Name and address of who will receive the information: _____

_____

Information being requested: _____

The information is being requested for the following reason: _____

- I understand by signing this form I authorize Melbourne Dermatology Center to either obtain or release the information I have requested to or from the above listed doctor or facility.
- I understand that in signing this form I authorize the disclosure of the protected health information described above. I understand that this authorization is voluntary. I understand that if the organization I authorize to receive the information is not a health plan or health care provider, federal or state law may no longer protect the released information and it will no longer be private.
- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it if I ask for a copy of the signed form.
- I understand I have the right to refuse authorization.
- The authorization will be in force until date: ___/___/___ or(event)_____at which time expires. (required-you must specify a date or event. Lifetime is not valid)
- I understand that the health information released may include information relating to sexually transmitted disease, acquired immune-deficiency syndrome (AIDS), or human Immunodeficiency virus (HIV). The release may also include any information relating to behavioral or mental health services and treatment for alcohol and drug abuse.

_____

Signature of patient or guardian **Date**