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Board Certified Dermatologist
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: ____

Address: ____

Date of Birth: ____________________ Phone Number: ______________________________

PROVIDER The person you are requesting information from	Name: ______________________________ Address: ______________________________ Phone: ________________ Fax: ____________
REQUESTOR The person you are wanting information sent to	Name: ______________________________ Address: ______________________________ Phone: ________________ Fax: ____________

All records related to: ____ (Please indicate if there is a specific condition or if all records for the patient.)

All Records from __________ to __________

Notice to Patient: When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. You have the right to revoke the authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the staff at Boise Dermatology. You do not have to sign this authorization and your refusal to sign will not affect your consent to use or disclosure of your protected health information for purposes of treatment, payment or health care operations. Photocopies, facsimile or scan of this Authorization shall be the same as a signed original.

Patient's Signature: ____ Date: ____________

Printed Name of Parent or Legal Guardian: ________________________________ Date: ____________

Signature of Parent or Legal Guardian: ___________________________________ Date: ____________