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# Authorization Form for Release of Confidential Health Information

Patient Name _____ Date of Birth _____

Home Address _____

I hereby authorize Lake Shore Dermatology to release to/receive from (circle one):

_____
*(Name of Health Care Facility, Physician, Agency, etc.)*

_____
*(Street Address, City, State and Zip Code)*

_____
*(Phone Number)* *(Fax Number)*

the following information:

- ❑ information in health care records, excluding HIV/AIDS test results, which may include history and physical examinations, records of care and treatment progress and prognosis, laboratory results, and pathology reports.
- ❑ HIV/AIDS records
- ❑ Other (specify)_____

The purpose(s) of this disclosure is (are):

- ❑ Further care/service
- ❑ Personal use
- ❑ Legal purposes
- ❑ Other (specify) _____

This consent shall remain in effect from _____ to _____.
*(Date)* *(Date)*

(If not specified, this authorization will expire 90 days from date signed below.)

I understand that:

- I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.
- The practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- This authorization is valid until it expires, unless revoked before that.
- I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

Signature of patient or legal guardian: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____