CLARITY DERMATOLOGY
AND COSMETIC CENTER

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.

I, _____ hereby authorize
(Your name/relationship to patient)

_____to release health information on
(Physician/Healthcare Facility)

_____, _____
(Patient's name) (Patient's date of birth)

regarding the patient's medical history (which may contain sensitive information), illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To:

_____
(Physician or healthcare facility name to receive health information)

_____
(Address)

_____
(Fax Number)

_____
(Telephone Number)

The medical information/records will be used for the following purpose:

_____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information:

_____

_____

DURATION

This authorization shall be effective immediately and remain in effect for 1 year.

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I understand that there is a 25 cent ($0.25) fee per page for any hard copies that are requested and that the full postage cost (if mailed) will be my financial responsibility. I understand that these fees and the total cost must be paid in full before this request is completed.

_____	_____	_____
Printed name of patient	Signature	Date

_____	_____
Printed name of *legal/personal representative*	Legal Relationship

_____	_____
Signature of *legal/personal representative*	Date

On Behalf of _____ (name of patient).

_____	_____	_____
Witness Name	Signature	Date