KNOTT STREET
DERMATOLOGY

Authorization for Release of Protected Health Information

Patient Name _____ Date of Birth _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip _____

Daytime Phone _____ Evening Phone _____ Email Address _____

I authorize you to **OBTAIN** health care information **FROM**:

Name _____

Title/Organization _____

Street _____

City/State/Zip _____

I authorize you to **SEND/DISCLOSE** health care information **TO**:

Name _____

Title/Organization _____

Street _____

City/State/Zip _____

☐ Patient to pick up ☐ Please mail ☐ Please fax to _____

Please disclose the following information (up to 6 years):

☐ All dermatology progress notes and correspondence
☐ All skin pathology reports
☐ All laboratory reports generated for dermatology over the preceding 3 months

I understand that my records may contain information pertaining to psychiatric conditions, sexually transmitted diseases, HIV, HIV-related illnesses, AIDS, drug and alcohol abuse. I give my specific authorization for these records to be released UNLESS I have initialed the lines below.

____ HIV, HIV-related illness, AIDS, AIDS-related illness ____ Sexually transmitted diseases

____ Psychiatric disorders/mental health treatment ____ Drug and/or alcohol use

Reason for disclosure:

☐ Referral or second opinion ☐ Transfer of care ☐ Other: _____

I intend for this authorization to expire on the following date: _____ ☐ None/No Expiration

I understand that I do not have to sign this authorization form in order to receive treatment.

By signing this form, I authorize Knott Street Dermatology to use and disclose Protected Health Information about me for the reasons mentioned above. I have the right to revoke this authorization at any time, in writing and signed by me. However, such a revocation shall not affect any disclosures already made regarding my prior authorization.

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

_____ _____
Patient (or legally authorized representative) signature Date

_____ _____
Relationship to patient (if not signed by patient) Printed Name (if not signed by the patient)