

ALABAMA DERMATOLOGY ASSOCIATES, P.C.

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DIPLOMATES
American Board of Dermatology

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY THE PRACTICE**

By signing this authorization, I authorize Alabama Dermatology Associates, PC to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Alabama Dermatology Associates, PC to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

{**ONLY INCLUDE IF CORRECT UNDER THE CIRCUMSTANCES:** The Practice will receive payment or others remuneration from a third party in exchange for using or disclosing the PHI.}

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. The authorization will expire on one year from today's date.

I do not have to sign this authorization in order to receive treatment from Alabama Dermatology Associates, PC. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address at the top of this form.

Signed by: _____
Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

DOB

Date

Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION