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AUTHORIZATION FOR RELEASE OF INFORMATION FOR PURPOSES REQUESTED BY PHYSICIAN'S OFFICE FROM ANOTHER COVERED ENTITY

I, _____, hereby authorize _____ to disclose the following protected health information to Dr. _____ of Alabama Dermatology Associates, PC at 4410 Watermelon Road, Northport, Alabama 35473.

Specific Description of Information to be Disclosed Including Date(s):

_____

This protected health information is being used or disclosed to carry out treatment, payment, and/or health care operations of Dr. _____ in the following manner: _____

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by notifying Alabama Dermatology Associates, PC at 4410 Watermelon Road, Northport, Alabama 35473. I understand that a revocation is not effective to the extent that Alabama Dermatology Associates, PC has relief on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Dr. _____ of Alabama Dermatology Associates, PC will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____ _____ _____
Signature of Patient or Personal Representative | Date of Birth | Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority