ADBH ADVANCED DERMATOLOGY OF THE BLACK HILLS, P.C.

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

NAME LAST	FIRST	M.I.	EMAIL ADDRESS

MAILING ADDRESS	CITY	STATE ZIP CODE	DATE OF BIRTH
			MO. - DAY - YR.

HOME PHONE	CELL PHONE	WORK PHONE
( )	( )	( )

PURPOSE

(PLEASE CIRCLE) AT THE REQUEST OF THE PATIENT CONTINUING CARE ATTORNEY

OTHER (SPECIFY) _____

INFORMATION TO BE DISCLOSED

(PLEASE CIRCLE) PROGRESS NOTES LABORATORY TESTS

HISTORY AND PHYSICAL PROCEDURE/OPERATIVE NOTES

REQUEST RECORDS FROM

NAME: ADVANCED DERMATOLOGY OF THE BLACK HILLS, P.C.

ADDRESS: PO BOX 1473

RAPID CITY, SD 57709-1473

EMAIL: adbhrc@gmail.com

SEND RECORDS TO

NAME: _____

ADDRESS: _____

_____

PHONE & FAX: _____

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand if my health record includes information relating to behavioral or mental health services, treatment for any alcohol and/or drug abuse, sexually transmitted disease, Hepatitis B or C testing, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), it will be included in this release of records.

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting my request in writing, except to the extent that action has already been taken to comply with it. I understand that I do not have to sign this authorization. I understand that my treatment or payment for services will not be denied if I do not sign this form. Without my express revocation, this authorization will expire one year from date of signature.

COPY OF AUTHORIZATION: A copy or fax of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing. A copy of this signed authorization will be provided to the patient.

RE-DISCLOSURE: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy laws or regulations.

If other than patient indicate relationship to:

_____Parent _____Guardian/Legal Representative _____ Other (please specify):_____

Signature: _____ Signature Date: _____