ADA DERMATOLOGY, P.A.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

Patient Name: ____Date of Birth___________

By signing this authorization, I authorize Ada Dermatology to use and/or disclose certain protected health information (PHI) contained in my medical records in the following manner:

From: ____

Physician/Institution that presently has data

____

Street Address City State Zip Phone

To: ____

Physician/Institution requesting data

____

Street Address City State Zip Phone

Release the following Protected Health Information:

______Office Notes ________Operative Reports _______Pathology Reports ______Lab Reports
_____ Other ___________________________

(Describe the information to be used or disclosed, including date of service, type of service, level of detail to be released or specific information)

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Release the requested PHI to include dates of service from___________ to ____________

We kindly request that you mail in records consisting of 20 pages or more.

I understand that my records may contain information regarding drug or alcohol abuse, mental illness, psychiatric treatment and/or sexually transmitted disease, including HIV(AIDS) information. I give my specific authorization for these records to be released.

I do not have to sign this authorization in order to receive treatment from Ada Dermatology. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to inspect or copy the protected health information to be used or disclosed. I have the right to revoke this 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: Ada Dermatology, 6454 Emerald St., Boise, ID 83704.

Signed by: ___________________________________ ________________________________

Signature of Patient or Legal Guardian Date