

**Dermatology Professionals, PA**  
**13359 Isle Drive, Suite 3 • Baxter, MN 56425**  
**218-454-7546 Fax 218-454-3062**

**Authorization for the Use or Disclosure / Release of Protected Health Information**

I authorize **Dermatology Professionals, PA** to use and disclose **Protected Health Information (PHI)** subject to the specifications listed below.

<p>____ <b>Disclose/Release to:</b></p> <p>____ <b>Obtain from:</b></p>	<p><b>Provider/Facility:</b> _____</p> <p><b>Address:</b> _____</p> <p><b>City/State / Zip:</b> _____</p>
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**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_  
 Please Print

**Address:** \_\_\_\_\_ **City/State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Dates of Service:** \_\_\_\_\_ **Phone (\_\_\_\_) \_\_\_\_\_**

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| <p><b>Request:</b></p> <p>____ All PHI for dates of services specified</p> <p>____ Progress Notes</p> <p>____ Immunization Records</p> <p>____ Worker's Compensation Records</p> <p>____ Laboratory Results</p> <p>____ Xray Films</p> <p>____ Xray Reports</p> <p>____ Other _____</p> | <p><b>For:</b></p> <p>____ Personal Use</p> <p>____ Moving Elsewhere</p> <p>____ Insurance Reasons</p> <p>____ Changing Providers</p> <p>____ Consultation Elsewhere</p> <p>____ Legal/Litigation</p> <p>____ Worker's Comp</p> <p>____ Other _____</p> |
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**Specific Release Required**

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavior or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the organization(s) or individual(s) listed above.

**Signature** \_\_\_\_\_

A faxed copy or photocopy of this unaltered authorization is allowed. This authorization expires when this request has been completed **or** on \_\_\_\_\_. I understand that if I extend the time period, I have the right to revoke this authorization in writing, but that any released PHI would be exempt from the revocation. I recognize that the PHI used or disclosed may be re-disclosed by the recipient and no longer be protected by Federal Privacy standards. PHI in your chart not generated by Dermatology Professionals, PA will not be released to another facility. I release Dermatology Professionals, PA from all legal responsibility or liability that may arise from this authorization.

I understand that I have the right to have a copy of this authorization and to inspect or copy the health information that I have authorized to be used or disclosed. I also understand that I do not have to sign this form and that the person and or organization listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to not sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorization disclosure. Since authorization is needed to release information to payers for certain mental health services and HIV testing, if I refuse to sign this form for this purpose, I understand I will be responsible for paying the entire bill for these services).

I have reviewed and understand this authorization. By signing this form, I acknowledge that it is accurate and reflects my wishes.

\_\_\_\_\_  
 Signature of Patient / Legal Representative\*                      Date                      Witness

\* \_\_Parent    \_\_Guardian    \_\_POA of HealthCare    \_\_Executor or Personal Representative of deceased patient