DERMATOLOGY
PROFESSIONALS, PA

13359 Isle Drive, Suite 3 • Baxter, MN 56425
Phone: 218-454-7546 • Fax: 218-454-3062

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

Patient's Name: _____
Please Print

DOB: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize Dermatology Professionals, PA to use and disclose Protected Health Information (PHI) subject to the specifications listed. I understand that the information in my health record may include information related to sexually transmitted disease(s), 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 UNLESS YOU RESTRICT IT. ☐ I do not release the PHI listed above.

Please select from options A, B and C below for your record request.

A: ☐ For personal use: I would like the records: ☐ Mailed ☐ Available for pick- up

B: ☐ Release to: **C:** ☐ Obtain from:

Provider/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Dates of Service Requested: _____

Request:

☐ Pathology Reports ☐ Mohs Notes ☐ All PHI for dates of services specified
☐ Surgical Reports ☐ X-ray Reports ☐ Worker's Compensation Records
☐ Laboratory Results ☐ Progress Notes ☐ Other _____

For:

☐ Continuation of Care **Please allow 30 days for completion of request
☐ Records are needed by a specific or future appointment date: _____

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:** _____

☐ Parent ☐ Guardian ☐ POA of HealthCare ☐ Executor or Personal Representative of deceased patient

Witness: _____