AUTHORIZATION FOR USE OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Patient: Name_____ Date of Birth_____

I. Authorization to share my information

I authorize the following: **DCM Skin Solutions Muncie, Carmel, Marion, to use or disclose the following health information.**

(check all that apply)

☐ - All of my Dermatology information

☐ - My Dermatology information relating to the following treatment or condition (list below):

_____

☐ - My Dermatology information covering the period from _____ (date) to _____ (date)

☐ - Other: _____

DCM Skin Solutions may disclose my health information to the following recipient/s:

Name (or title)/ organization_____

Relationship to Patient_____

Address _____

City _____ State _____ Zip _____

PH: Cell / Home_____ Fax _____ Email _____
(Circle one)

Name (or title)/ organization _____

Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

PH: Cell / Home _____Fax _____ Email _____
(Circle one)

Name (or title)/ organization _____

Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

PH: Cell / Home _____ Fax _____ Email _____
(Circle one)

When to disclose this health information: (check one): ☐ - Anytime ☐ - At my request

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

At any time, I can request a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____