AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

I authorize the disclosure/request of the named individual's health information as described below. The following individual or organization is authorized to make the disclosure/request:

River Region Dermatology and Laser, PC
2060 Berryhill Road
Montgomery, AL 36117
(334) 676-3366

FOR OFFICE USE ONLY

This information may be disclosed to/requested from and used by the following individual or organization:

_____
Name of Recipient (Provider)

_____
Address

_____
City State Zip

Additional Recipient (Provider): _____
_____
_____

The type and amount of information to be disclosed/requested is as follows:

- o Complete Medical Record
- o History and Physical
- o Lab Reports (Specify) _____
  _____
- o X-Ray
- o Medical Discharge Summary
- o Nursing Summary
- o Other: _____

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

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from date signed. I understand that I may contact the Privacy Officer at any time with questions about disclosures or to present my written revocation.

I understand that authorizing the disclosure/request of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure services/treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Reason for Disclosure
Continuation of Care: ____
Medical Consultation: ____
Attorney Inquiry: ____

Social Security: ____
Insurance Claim:____

Please Sign Here _____ _____
Signature of Patient/Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness