

# Peraza Dermatology Group

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## HIPAA Patient Authorization for Release of Health Records FROM Peraza Dermatology Group

1. I authorize Peraza Dermatology Group to disclose information from the health records of:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Patient Full Name)

2. **The information is to be disclosed to:** \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

I authorize this information to be routed in the following ways:

Written/Photocopy/Paper to be picked up       Fax       Mailed

**Purpose of the disclosure:**

Continuity of Care     Transfer of Care     Personal Use     Emergency Treatment     Legal     Other

3. **Dates of Treatment:** From: \_\_\_\_\_ To: \_\_\_\_\_

**I have marked specific reports to be disclosed**

Progress Notes       Laboratory Reports       Operative/Surgical Reports

Medications / Allergies     Biopsy/Pathology Reports     Consultation Reports

Allergy Test Treatment

Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)

Other (Specify): \_\_\_\_\_

I give specific authorization to disclose the following information:

HIV test results       Documentation of AIDS diagnosis

Drug and alcohol abuse treatment records     Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Peraza Dermatology Group in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or New Hampshire and/or Vermont privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time:

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

\_\_\_\_\_  
Signature of Patient (or Patient Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Patient Representative

\_\_\_\_\_  
Authority of Representative to Act for Patient  
(Relationship to Patient)

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