Peraza Dermatology Group

252 Broad Street

Claremont, New Hampshire 03743

Telephone: 603.542.6455 | Facsimile: 603.543.0736

www.perazaderm.com

José E. Peraza, M.D., F.A.A.D. | Daniel M. Peraza, M.D., F.A.A.D. | Ashwin L. Kumar, P.A.-C | Kira M. Schachinger, P.A.-C

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

. I authorize Peraza Dermatology Group to disclose inic	
Name:	Date of Birth:
(Patient Full Name)	
. 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. ☐ Written/Photocopy/Paper to be picked up. ☐ F	ng ways: Fax □ Mailed
Purpose of the disclosure: □ Continuity of Care □ Personal Use □	Emergency Treatment Legal Other
B. Dates of Treatment: From:	To:
 Medications / Allergies Allergy Test Treatment Entire Health Records (including, but not limit demographics, referral documents, and records fr 	ratory Reports Operative/Surgical Reports sy/Pathology Reports Consultation Reports ted to, information regarding medical/health treatment, insurance, rom other facilities.)
I give specific authorization to disclose the following i ☐ HIV test results ☐ Drug and alcohol abuse treatment records	information: Documentation of AIDS diagnosis Psychiatric/Mental Health treatment records
longer be used or released for the reasons covered by	ission at any time. If I withdraw my permission, my information may not by this authorization. However, any disclosures already made with my this authorization by notifying Peraza Dermatology Group in writing.
	n of this authorization form. The information to be released by this ganization that receives it and may no longer be protected by Federal o
Unless revoked earlier, this authorization expires in or	ne year unless I specify another time:
records as authorized on this form. I understand that	authorization from legal responsibility or liability for the disclosure of the this authorization is voluntary and that I may refuse to sign it. I will be ted. 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)