Diplomat American Board of Dermatology

Fellow American Academy of Dermatology

Patient Authorization for Release of Protected Health Information

By signing this authorization, I authorize Rivergate Dermatology, PLLC to use and/or disclose certain protected health information (PHI) about me to or for the parties listed below.

This authorization permits ____________________________________to use or disclose to the following:

____

Party Receiving Information

____

____

Address, Fax number or Email to send PHI

Specific individually identifiable health information to be released is listed below. (date(s) of service, level of detail to be released, origin of information, etc.)

____

____

If you do not want certain portions of your medial records released, please initial the spaces below. Leave blank if this does not apply to your request.

______AIDS/HIV ______Substance Abuse ______Psychiatric Conditions ______Other (Please Specify)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclose by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent the Rivergate Dermatology, PLLC has acted in reliance upon this authorization. My written revocation must be submitted to Rivergate Dermatology, PLLC, Privacy Officer, 201 Bluebird Drive Goodlettsville, TN 37072.

Patient Name:______________________________________ DOB:_________________________________

Signature:____ Date:_________________________________