Advanced Dermatology and Skin Cancer Center
2735 Pembrook Place
Manhattan, KS 66502
PHONE (785) 537-4990 | FAX 785.537.1938

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION[1]

Date of request:___________________ Patient Name:____

DOB:__________________________ Patient's Phone Number:________________________________

Patient's Address: ____

From Persons, facility, or class of persons who are authorized to disclose the records/information:
❑ Advanced Dermatology and Skin Cancer Center, P.A.

❑ Other (name & address)____
____

To Persons, facility, or class of persons who are authorized to receive the records/information:
❑ Advanced Dermatology and Skin Cancer Center, P.A.

❑ Other (name & address)____
____

Requested delivery thru: ❑ Mail ❑ Fax: (_____)______________ ❑ Patient will pick up

Information to be released:
(check all that apply)

❑ Pathology Reports: ❑ All ❑ Date(s) ____________________________
❑ Lab Reports: ❑ All ❑ Date(s) ____________________________
❑ Complete Copy of Medical Record*
❑ Date Range: **from** ___________________ **to** ______________________
❑ Only Diagnosis & Treatment Records Pertaining to: ______________________
list diagnosis or procedure
❑ HIV/AIDS Status
❑ Itemized Statement: Date of Service: _____________________________

***"**Complete Copy of Medical Records" means all protected health information in a designated record set, which includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices (this includes all records including records from other health care providers).

Reason for request:

❑ Moving
❑ Providing a copy for my primary care physician
❑ Transferring care to another provider
❑ Not a provider with my insurance plan
❑ Other _____________________________________

Expiration:
This "Authorization" will expire on _____________ (MM/DD/YY)
or on the following specific event: ___________________________
If no date or event is specified this request will expire 6 months from date of signature.

- I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.
- I also understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization.
- I also understand that I may revoke this authorization at any time by delivering/mailing a *written* revocation to the party or attorney or law firm named in "Authorized to Receive" above.
- If I revoke this authorization it will have *no* effect on actions already taken on reliance on this form.
- I also understand that the covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it.
- I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

____ ________________________

Patient Signature (or Patient's Personal Representative, if applicable) *Date of Signature*

____

Personal Representative's Relationship/Capacity to Patient

____

Printed Name of Personal Representative

____

Printed address & telephone number of Personal Representative

[1]This authorization should not be utilized for uses or disclosures related to the sale of protected health information, marketing or research.