QUALDERM PARTNERS™
A SKIN & AESTHETICS WELLNESS FAMILY

Authorization to Use or Disclose Health Information

Patient Name:_____ **Date Of Birth:**_____

Please print full name

1. I authorize the use or disclosure of the above named individual's health information by_____ as described below.

2. The type of information to be used or disclosed is as follows:

☐ My complete medical records **or** check the appropriate boxes below,

☐ Clinic Note	☐ Progress Note	☐ Anesthesia/Sedation Record	☐ Other (Specify below):
☐ Prescription History	☐ Consultation Note	☐ Bill for Service	
☐ Laboratory Result	☐ Radiology Report	☐ History and Physical Report	
☐ Operative/Procedure Report	☐ Pathology Report		

_____

The above information can be released from the date of _____through _____
Or ☐ the period of time encompassing all dates of service at

3. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.

4. The information identified above may be used or disclosed to and/ or requested from the following individual(s) or organization(s):

_____

Name of Organization or Individual

_____

Address

_____ _____

Phone Number Fax Number

5. This information for which I am authorizing disclosure will be used for the following purpose:
☐ my personal use ☐ sharing with other health care providers ☐ workman's compensation
☐ other: _____

6. 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 and present my written revocation to the medical record department. 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.

7. This authorization will expire on ☐_____ (Date) or ☐is valid as long as I am a patient of this practice. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.

8. I understand that once the above information is disclosed, the recipient may redisclose it, and the federal privacy laws or regulations may not protect the information.

9. I understand the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment.

_____ _____

Signature of patient or legal representative Date

_____

If signed by legal representative, relationship to patient

_____ _____

Signature of witness Date