River City Dermatology, PLLC

6741 Fulton St E, Ada, MI 49301 Phone:616-320-5450 Fax: 616- 320-0165

Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth: _____

- □ Furnish a copy of the following medical records
- □ Verbal disclosure of the following medical records

Receiving Party: **River City Dermatology , PLLC** Time Period from _____ to _____

- □ Laboratory Data
- □ Radiology Reports
- □ Progress/Doctor's Notes
- □ Operative Reports, Findings & Complications
- □ Other Documents (please specify) _____
- □ Hospital Notes
- □ ER Notes
- □ Pathology Reports
- □ Entire Chart

Physician/Practice releasing records:
Name: _____
Address: _____
City/State/Zip: _____
Phone: (____) _____
Fax: (____) _____

Physician/Practice to receive records:
Name: River City Dermatology, PLLC
Address: 6741 Fulton St E
City/State/Zip: Ada, MI 49301
Phone: 616-320-5450
Fax: 616-320-0165

I authorize the release of these medical records *to* **River City Dermatology, PLLC** to all physicians, relevant healthcare facilities and diagnostic centers involved in the course of my treatment. I agree that the information may be faxed for expediency.

I specifically consent to the disclosure as indicated above that may contain the following information:

- □ Alcohol/drug/substance abuse information _____ (initials)
- □ HIV test results or diagnosis of AIDs and AIDs related conditions _____ (initials)
- □ Mental health information _____ (initials)
- □ Pregnancy information _____ (initials)
- □ Sexually transmitted diseases (STD) information _____ (initials)

If not previously revoked, this authorization to use or disclose protected health information will expire TWELVE (12) months from the date of my signature or as otherwise specified by date, event or conditions(s) as follows:

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: _____. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party**.** [If applicable because the authorization is obtained for marketing purposes] I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

_____ _____
Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority