HEARTLAND DERMATOLOGY AND SKIN CANCER CENTER, PA

Authorization For Release Of Health Information

This Authorization for disclosure of Health Information is effective for one year unless specified and is subject to revocation at any time in writing. Prohibition on redisclosure –This information which has been disclosed to you from confidential records may be protected by federal law. Federal regulations (45 CFR 164.508; 42 CFR part 2) Distribution of Copies: Original to provider, copy to patient, copy to accompany use or disclosure

Patient Name:_____ Date of Birth:_____
(Please Print)

Last 4 of SSN:_____ Provider:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual(s) or organization(s) are authorized to make the disclosure:
HEARTLAND DERMATOLOGY AND SKIN CANCER CENTER, PA
3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)
☐ Entire record ☐ Medication list ☐ List of allergies ☐ Pathology results (please list the dates you would like disclosed) ☐ Other (please describe):
_____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. The information identified above may be used by or disclosed to the following individuals or organization(s):
Name: _____
Address (**City, State, Zip**): _____
Phone/Fax number: _____
OR
6. Request records from previous provider:
Name: _____
Address (**City, State, Zip**): _____
Phone/Fax number: _____
7. This information for which I'm authorizing disclosure will be used for the following purpose:
☐ My personal records
☐ Transfer of Care
☐ Continuity of Care
☐ Other:_____
8. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____
Signature of Patient or Legal Representative

_____
Relationship of Patient Representative to Patient

_____
Date