South Coast Dermatology
Patient Authorization for Practice to Release
Protected Health Information

Patient: _____

Account #: _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Individuals who may use or disclose this information:

South Coast Dermatology
97 Libbey Parkway, Suite 400
Weymouth, MA, 02189

Individuals who may receive and use the disclosed information:

Name:_____

Address_____

City_____State_____Zip_____

Tel:_____Fax:_____

The above-mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to the Practice.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This authorization was signed by: _____ Date: _____

Patient or Representative Signature

Relationship to Patient (if other than patient): _____Date: _____
Please indicate the time frame you are requesting:
___Last 3 years ___Last 5 years ___Entire Medical Record