HIPAA AUTHORIZATION

THIS AUTHORIZATION OUTLINE WITH WHOM MEDICAL INFORMATION ABOUT YOU MAY BE SHARED. PLEASE READ IT CAREFULLY.

The privacy of your medical information is important to us. Our Notice of Privacy Practices outlines how we may use or disclose your medical information on a regular basis. This Authorization is for situations not included in the Notice when you may want us to share your medical information with someone else, such as a spouse, other family members, or your caregiver. This Authorization will go into effect on the date signed below and will remain in effect for a period of five years.

HEALTH INFORMATION AUTHORIZED TO BE DISCLOSED

The following information may be disclosed:

- ☐ Information about my general medical condition
- ☐ Information about a specific medical condition including surgical or laboratory results
- ☐ Information about medications which are prescribed for me
- ☐ Financial information related to my care
- ☐ Other medical information Specify:_____

WHO MAY RECEIVE THIS INFORMATION

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that once disclosed to the individual(s) named above, Mountain Laurel Dermatology cannot guarantee that the individual(s) will maintain the confidentiality of such information as described by law.

_____

Patient Name Date of Birth

_____

Signature of Patient or Authorized Representative

_____

Printed name of Authorized Representative and Relationship

REVOCATION: This Authorization will remain in effect for a period of five (5) years from the date signed. However, you have the right to revoke this Authorization at any time as long as the revocation is made in writing and is received and acknowledged by Mountain Laurel Dermatology. Such revocation will restrict future disclosures of your medical information but cannot affect past disclosures or disclosures underway at the time of receipt.

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