Peraza Dermatology Group

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HIPAA Patient Authorization for Release of Health Records FROM Peraza Dermatology Group

1. I authorize Peraza Dermatology Group to disclose information from the health records of:

Name: _____ Date of Birth: _____
(Patient Full Name)

2. **The information is to be disclosed to**: _____

Address _____

City, State, Zip: _____

Contact Person: _____

Phone/Fax: _____

I authorize this information to be routed in the following ways:
❑ Written/Photocopy/Paper to be picked up ❑ Fax ❑ Mailed

Purpose of the disclosure:
❑ Continuity of Care ❑ Personal Use ❑ Emergency Treatment ❑ Legal ❑ Other

3. **Dates of Treatment:** From: _____ To: _____

I have marked specific reports to be disclosed
❑ Progress Notes ❑ Laboratory Reports ❑ Operative/Surgical Reports
❑ Medications / Allergies ❑ Biopsy/Pathology Reports ❑ Consultation Reports
❑ Allergy Test Treatment
❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
❑ Other (Specify):_____

I give specific authorization to disclose the following information:
❑ HIV test results ❑ Documentation of AIDS diagnosis
❑ Drug and alcohol abuse treatment records ❑ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Peraza Dermatology Group in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient (Relationship to Patient)