Avail DERMATOLOGY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Last Name: _____ First Name: _____ Middle initial: _____

Date of Birth: Month _____ Day: _____ Year: _____ Social Security #: _____

Legal Guardian's Last Name: _____ Legal Guardian's First Name: _____

Phone number: _____ Fax number: _____ E-mail: _____

I hereby authorize the use and/or disclosure of my individually identifiable health information as indicated below. I understand that this authorization is voluntary and that if the entities authorized to share the information are not health plans or healthcare providers, then the shared information may no longer be protected by federal privacy regulations.
Additionally, I acknowledge that (per HIPAA guidelines) my private health information may be transmitted via facsimile or securely emailed and used as originals, provided that at least 300 dpi (dots per inch) is used in the facsimile or email.
This is part of this practice's ongoing efforts to keep your private health information secured digitally and limiting the inherent risks of paper based private health information.

Please circle one:
Entity RELEASING or RECEIVING the information:

Avail Dermatology
710 Newnan Crossing Bypass
Newnan, Georgia 30263
Phone: 770-251-5111 Ext. 9010
Fax: 770-254-8680

Please circle one:
Entity RELEASING or RECEIVING the information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

NFORMATION TO BE DISCLOSED *(check the appropriate lines and include other information where indicated):*

____ All records
____ Summary Health Information: (includes Discharge Summaries, History and Physical, Radiology, Pathology, Laboratory, Nursing and Operative reports/dictated notes)

____ Demographics and History
____ Neuropsychological/Psychological evaluations and/or consultations
____ Clinical Therapy evaluations and progress notes/reports (Occupational, Speech and/or Physical Therapies)
____ Information relating to psychiatric and/or psychological diagnosis, symptoms, prognosis, and treatment
____ Information related to treatment of alcohol and/or drug abuse.
____ Other: _____

THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING PURPOSE:

____ Sharing with health care providers
____ Insurance use
____ Legal use
____ Personal use
____ Other: _____

I request that the following information not be shared: _____

I understand and agree to the following (**Please read and initial the statements below**):

____ I have the right to revoke this authorization in writing unless the Medical Records (PHI) has already been released or if otherwise prohibited by state or federal law.
____ I have the right under the Federal Protected Health Information regulations to make amendments where appropriate.
____ I understand that my health information may be subject to re-disclosure by the recipient and not protected by federal and/or state privacy laws.
____ I understand that the authorizing of the disclosure of information identified above is voluntary and this Authorization is not intended to alter receiving healthcare and treatment services from any health care provider or payment for your healthcare.
____ I understand that I may see and copy the information described on this form if I ask for it and get a signed copy.

This information will expire on the following date or event: _____

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE SIGNED, UNLESS OTHERWISE INDICATED.

_____ _____
Client's signature Date

_____ _____
Legal Guardian signature, if applicable Date

_____ _____
Avail Dermatology Employee Date