DERMATOLOGY SPECIALISTS, P.A.
Authorization for Use and Disclosure of Patient Health Information

I, _____, authorize Dermatology Specialists, P.A. to use or disclose (as applicable) the following medical information: _____

_____

The information described above may be disclosed to the following recipient(s): _____

_____

The use or disclosure (as applicable) is for the following purpose(s):

- ☐ At the request of the patient
- ☐ For research purposes
- ☐ Transfer of records to new physician
- ☐ Other, please specify: _____

_____

I understand that Dermatology Specialists, P.A. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes, Dermatology Specialists, P.A. will not provide the treatment if I am unwilling to sign this authorization form.

- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Dermatology Specialists, P.A. will not provide the treatment if I am unwilling to sign this authorization form.

I understand that I may revoke this authorization by sending a written request for revocation to Dermatology Specialists, P.A.'s Privacy Officer. If I revoke this authorization, Dermatology Specialists, P.A. will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when Dermatology Specialists, P.A. discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

This authorization shall expire on _____.

I understand and agree to the terms of this authorization:

_____ _____ _____

Patient (or Patient Representative) Signature Account # Date

If signed by Patient Representative, state authority to act on behalf of patient:

_____