DERMATOLOGY SPECIALISTS

3316 West 66th Street, Suite 200, Edina, MN 55435
Phone: (952) 920-3808 Fax: (952) 920-8899

Authorization for Use and Disclosure of Health Information

All sections required; if left blank form will be invalid*

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

☐**ALL** ☐Billing ☐Appointments ☐Results ☐Other:_____
Please specify

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

_____

First, last names and relation - ie: John and Jane Doe, parents

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.

Authorization valid until revoked in writing by the patient, unless an alternative expiration date is provided here: _____ / _____ / _____.
Month *Day* *Year*

_____ _____
Patient (or Patient Representative) Signature **Date**

For office use only:
_____/_____ _____/_____
Account #'s Physician Staff initials