Authorization for Release of Protected Health Information

I hereby authorize Integrated Dermatology of Lakeport, LLC's employees and/or their designee to use and disclose protected health information from the record of:

Patient Name: _____

Date of Birth: _____

Dates of Service to be Released: From: _____/_____/_____ To: ____/_____/_____

OR ☐ All Dates of Service

For the following purpose: ☐ Medical Care ☐ Legal ☐ Insurance

☐ Other: _____

Release To:

I understand that copies of the records indicated above will be: (check one or more, as applicable)

☐ Sent to:
Name of Recipient: _____
Name of Company: _____
Address: _____
City: _____ State: _____ Zip Code:_____

☐ Faxed to
Name of Recipient: _____
Name of Company: _____
Fax Number: _____
Confirmation Telephone Number: _____

☐ Viewing Only
Name of Recipient: _____
Confirmation Telephone Number: _____

The information to be disclosed is:

☐ **Complete health record** (not including psychotherapy notes)

***OR* the specified records as indicated below:**

_____ Assessments
_____ Billing
_____ Consultation Reports
_____ Discharge Summary
_____ Laboratory Tests
_____ Medications/Treatments
_____ Physician Orders
_____ Photographs, Videotapes, or Digital or Other Images
_____ Progress Notes
_____ Therapy
_____ X-ray Reports
_____ Other: _____
_____

The information disclosed is to be sent by:

☐ **Mail** ☐ **Fax** ☐ **Via Internet (when applicable)**

☐ **Held for pickup by: _____**
(name of person authorized to pick up)

I understand that the disclosed information may include information relating to:

- Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection;

- Treatment for drug or alcohol abuse;
- Mental or behavioral health or psychiatric care.

7. I acknowledge the following statements:

_____ I understand that I generally may revoke this authorization at any time by
(Initial) notification in writing to Integrated Dermatology of Lakeport, LLC, Attn: Compliance Officer
902 Clint Moore Road
Suite 226
Boca Raton, FL 33487
of my intent to revoke this authorization, except that if I do not notify Integrated Dermatology of Lakeport, LLC in writing of my intent to revoke this authorization, such revocation will not have any effect on any actions by Integrated Dermatology of Lakeport, LLC taken before the revocation.

_____ Unless otherwise revoked, this authorization will expire on:
(Initial) _____

_____ (Initial) I understand that the Integrated Dermatology of Lakeport, LLC will give me a copy of this authorization form after I sign it.

I understand that my records are confidential and cannot be disclosed without my written authorization, except otherwise when permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records in accordance with applicable law.

X_____

Signature of Patient/ Patient's Legally Authorized Representative Date

(Representatives must present legal documentation that authorizes them to act on the patient's behalf)

_____ _____

Printed Name of Patient's Representative Relationship to Patient