OLANSKY DERMATOLOGY ASSOCIATES

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.
I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the enclosed information may be redisclosed and may no longer be protected by federal privacy regulations.

Patient Name _____ Date of Birth _____

Persons/Organization authorized to **release** the information: _____

Fax#_____ Phone# _____

Persons/Organization authorized to **receive** the information: _____

Address: _____

Fax#_____ Phone# _____

Specific description of the information (including dates) _____

The patient or patient's legal representative must read and initial the following statements:

1) I understand that this authorization will expire on _____ **Initials:____**
2) I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have an effect on any actions taken before the organization received the revocation.
Initials: ____
Send revocation to Olansky Dermatology Associates at the address below.

To be completed by the providing organization:

1) The purpose of the use or disclosure is: __to coordinate treatment & appointments for the patient___
2) The information will be used in the following manner: to assist the patient in his/her medical care___
3) The organization may receive direct or indirect remuneration or compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: The patient or the patient's legal representative may inspect and/or copy the protected health information to be disclosed in accordance with the organization's access policy.

The organization does not limit its right to make use or disclosure of your information that is required by law or permitted to avert a serious threat to the health and safety of the public.

_____

Signature of Patient or Patient's legal representative Date

Print Name of Patient or Patient's legal representative: _____Relationship _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. THE PRACTICE WILL NOT CONDITION TREATMENT OR PAYMENT ON THE PROVISION OF THIS AUTHORIZATION.