OLANSKY
DERMATOLOGY
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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.

**PRINT** Patient Name: _____ Date of Birth _____

Person/Organization AUTHORIZED TO RELEASE INFORMATION:

OLANSKY DERMATOLOGY ASSOCIATES
3379 PEACHTREE ROAD, NE
SUITE 500
ATLANTA, GA 30326-1418
Fax: 404-355-5787 Phone: 404-355-5484

Person/Organization AUTHORIZED TO RECEIVE INFORMATION: _____

Fax# _____ Phone#_____

Specific information requested (including date range):_____

_____

**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.
   **Initials:** _____

- The purpose of the use or disclosure is: to coordinate treatment and/or appointments for the patient.
- The information will be used to: assist the patient in his/her medical care.
- 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 patient's legal representative may inspect and/or copy the protected 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 health and safety of the public.

*Signature of Patient or Legal Representative:_____ Date:_____

*Printed name of Patient or Legal Representative:_____ Relationship:_____