HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

A. I, _____ give authorization for release of my protected health information (PHI) to **The Dermatology Group, LLC** regarding my billing, condition, treatment and prognosis to the following individual(s):

- Name _____ Relationship _____
- Name _____ Relationship _____
- Name _____ Relationship _____

B. I understand that I have the right to revoke this authorization verbally and/or in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

C. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____

Signature of Patient