DERMATOLOGY ASSOCIATES OF LANCASTER, LTD.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name ______________________ Account No. ____________

Maiden Name ______________________ Date of Birth ____________

Street Address ______________ City ________ State ____ Zip ____

( ) ____________ Phone

( ) ____________ Alternate Phone

I authorize the use/disclosure of health information about me as described below:

OBTAIN FROM (What organization) ____________

Address ____________

( ) ______ Phone

( ) ______ Fax

RELEASE TO (What organization) ____________

Address ____________

( ) ______ Phone

( ) ______ Fax

☐ Date(s) of Service: ____________

☐ Complete Medical Record ☐ Other: ____________

For the purpose of:

☐ Further Medical Care ☐ Personal ☐ Other (Please specify): ____________

☐ Changing Physicians ☐ Legal investigation/Action ☐ Insurance Eligibility/Benefits

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

State and Federal Laws protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug or Substance Abuse Records	☐ Yes	☐ No	Dates: ____________
HIV Testing and Results	☐ Yes	☐ No	Dates: ____________
Mental Health or Psychotherapy Records	☐ Yes	☐ No	Dates: ____________

Copying Fees:

I understand Dermatology Associates of Lancaster may receive compensation for medical record copying in accordance with Pennsylvania Law, 42 PA.C.S. §6152.

Please note that while Dermatology Associates of Lancaster, Ltd. does not charge patients requesting a copy of their own records, other medical practices and/or agencies may.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

Continued

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.

I understand that I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dermatology Associates of Lancaster. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires in 90 days, unless otherwise specified, not to exceed 1 year from date of signature.**

Signature of Patient or Personal Representative　　　Date

Name of Patient (Please print)

Signature of Witness　　　Date

If signed by person other than the patient, state relationship and authority to do so:

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased
☐ Power of Attorney for Healthcare ☐ Authorized Legal Representative

VERBAL AUTHORIZATION

If patient is physically unable to provide a signature and has records that are being released pursuant to the Pennsylvania Mental Health Procedures Act regulations, complete the following:

We, the undersigned, do verify that the above Authorization has been read to the client and that he/she has indicated understanding the nature of the Authorization and freely gives his/her verbal consent for the release of the above information.

Signature of Responsible Person　　　Date

Signature of Responsible Person　　　Date

PLEASE MAIL OR FAX THIS FORM TO:

Dermatology Associates of Lancaster, Ltd.　　FAX Number: 717 / 569.2187
Attention: Medical Records Department
1650 Crooked Oak Drive, Suite 200
Lancaster, PA 17601

If you have any questions, please call: 717 / 569.3279