Glenn H. Brown, MD
DERMATOLOGY
1450 S Dobson Rd, Suite 320B, Mesa, AZ 85202
480-835-9755 Fax: 480-964-8668
www. browndermatology.com

Authorization to Disclose Protected Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

RELEASE INFORMATION FROM: **FACILITY:** _____
ADDRESS: _____
PHONE/FAX: _____

What records do you want? (Check appropriate boxes below):

Date(s) of Service: _____/_____/_____ through _____/_____/_____
☐ Progress Note(s) ☐ All Medical Records ☐ Billing Records
☐ Test Results (X-Rays, Lab/Pathology Results) Please Specify: _____
☐ Other (Please Specify): _____
_____

How would you like your records delivered?
☐ Paper ☐ Fax ☐ Mail Delivery ☐ In-Person Pickup
☐ Electronic (Email, CD, Portal, Other) Please Specify: _____

_____ I **understand** that the information disclosed pursuant to this Authorization, **except** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal; privacy regulations or other applicable state and federal laws. **I understand** that I have a right to revoke this authorization at any time. **I understand** that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **I understand** that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or consent a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (Date) _____/ _____/ _____/ **If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (initial here _____) it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**
I understand that any disclosure of healthcare information carries with it the potential for unauthorized and suture re-disclosures, as allowed by HIPAA and other federal privacy rules. If have questions about disclosures of my health information, I can contact my provider of care.
This facility, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.
Signature:_____ **Date:** _____

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