Authorization for Use/ Disclosure of Protected Health Information (PHI)

Name of Patient (Please Print) / Date of Birth	Treating Facility:
Address	Aesthetic Dermatology, P.A. 210 North Highway 27 (Suite 1)
City, State, Zip Code	Clermont, FL 34711 Phone: (352) 243-2544 ◆ Fax: (352) 243-2745
Social Security Number	*Satellite Office:* *Lady Lake*

I hereby authorize Aesthetic Dermatology, P.A. to use or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization.

Authorizes Release of Protected Health Information (PHI):
(Check one)

❑**FROM** Aesthetic Dermatology, P.A. to:	❑**TO** Aesthetic Dermatology, P.A. from:
Name of Health Care Provider/ Plan/ Other	Name of Health Care Provider/ Plan/ Other
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone number / Fax Number	Phone number / Fax Number

Information to Be Released:
(Check appropriate categories)

❑Office Notes ❑Lab Reports ❑X-Ray Reports ❑Immunizations ❑Other (Specify): ________

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❑Other Test Reports ❑Photographs ❑Complete Medical Records

In addition, I authorize Aesthetic Dermatology, P.A. to release information relating to: (Initials required if applicable)

_____HIV/ AIDS _____Psychiatric care _____Genetic testing _____Drug/ alcohol abuse

Purpose of Disclosure or Use of PHI:
(Check appropriate categories)

❑Moving ❑Changing Provider ❑Second Opinion ❑Consultation

❑Insurance Change, Eligibility or Benefits ❑Legal Investigation or Action ❑Other (Specify): ________________________

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I understand that this authorization is valid for 12 months after the date signed, unless I otherwise specify, and applies to the requested PHI by the date of authorization below. I may revoke this authorization at any time by notifying Aesthetic Dermatology, P.A. in writing. I have reviewed and understand the content of this authorization form.

Signature of Patient or Legal Guardian	Date of Authorization